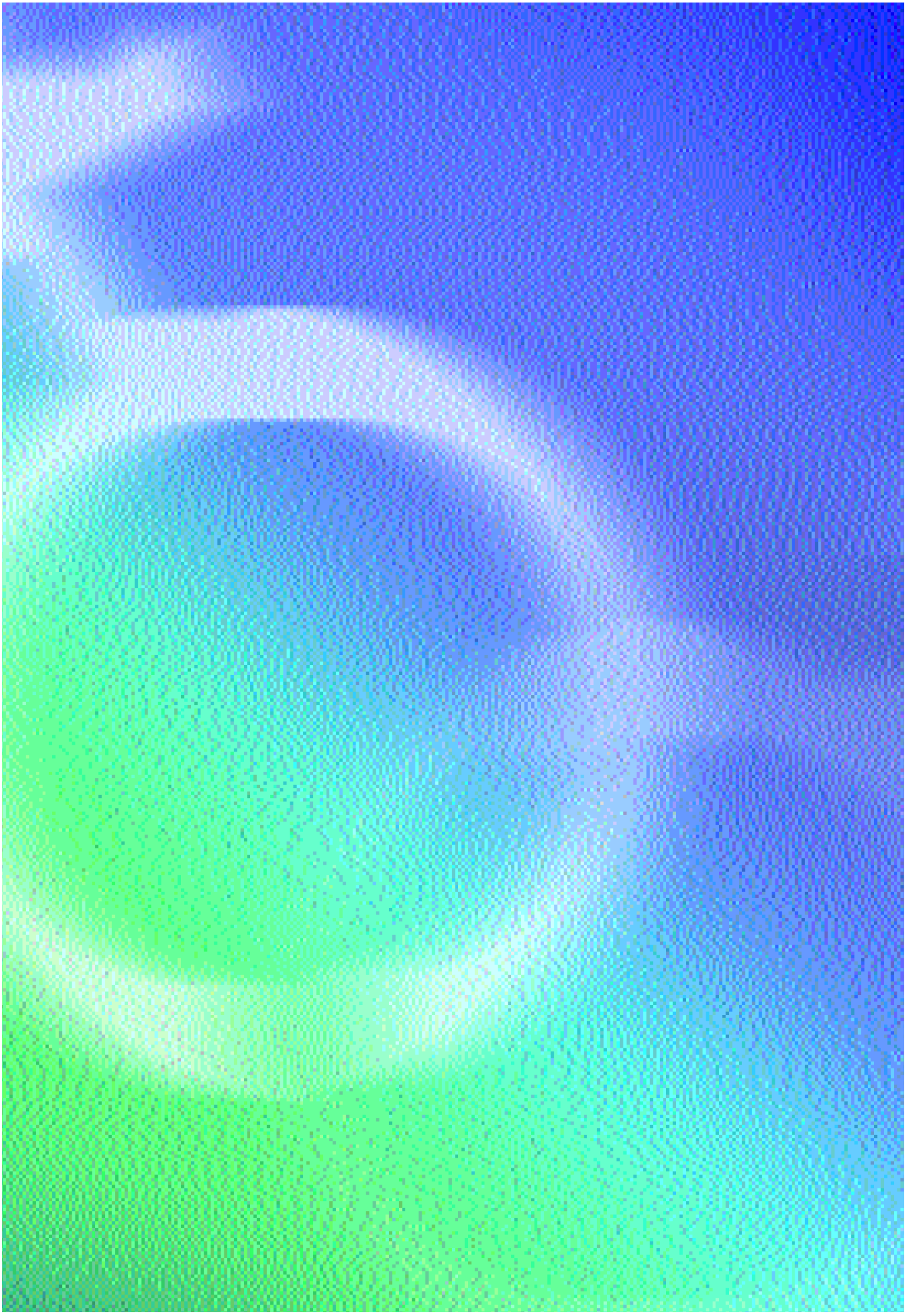

Walsall NHS
Primary Care Trust

Sexual Health in Walsall

The 2003 Annual Report of the Director of Public Health Medicine

Sexual Health in Walsall

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FOREWORD

A new Walsall Primary Care Trust (PCT) has been formed since my last Annual Report of 2002 when the Health Authority was coming to a close. The new PCT has taken on the challenge of continuing and enhancing work aimed at improving health, and has tried to seize on opportunities to meet the needs of Walsall people during a difficult first year in terms of constraints on available resources. The Public Health Team in the PCT has remained strong and ready to help meet these challenges and opportunities. We look forward to the immediate years ahead, when we do not expect to feel so constrained and when we intend to deliver on a number of public health initiatives.

One of these is sexual health. So much strategic planning, innovation and pilot initiative, effort and thought has gone into this area over recent years. This focus of activity has been boosted by the launch of the National Sexual Health and HIV Strategy. We now have our very own Walsall sexual health strategy that is informed by the national document but places priority on sexual health issues in Walsall based on need. Of course, we are living in a time when rates of sexually transmitted infections (STIs) have reached an unprecedented peak, recently attracting the attention of parliament and constantly inviting headline media statements. Sexual health is clearly controversial since everybody has an opinion on topics such as contraception, abortion, teenagers, sexual orientation, HIV, and the sex industry, to name but a few.

It seems appropriate and timely, therefore, to carry on the tradition of theme-based Annual Reports by devoting this year 2003 to Sexual Health in Walsall. As ever, my aim is not only to inform, but also to provoke discussion and consultation, and to encourage feedback. As part of this aim, I am particularly keen to inform all the strategic work across the borough and to address inequalities from the health standpoint. It is my hope that this annual report makes a significant contribution to this stated aim.

Dr Sam Ramaiah
Director of Public Health Medicine
August 2003

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DISCLAIMER
The names of people used in this report to provide case studies bear no relation to the actual identity of Walsall residents.

INTRODUCTION

The recent launch of the first national strategy for sexual health and HIV signifies a government re-priority in the face of an epidemic of sexual ill health. HIV was at the top of the 1992-1997 public health agenda but has slipped with the recent modernisation of the NHS. Since 2001, there have been more new diagnoses than in any previous year. Incidence of other sexually transmitted infections (STIs) has also risen dramatically, causing a crisis in delivery of genitourinary medicine (GUM) services.

Walsall has been no different. At the Manor Hospital GUM Department, raised caseloads in 2001 rose further in 2002 as illustrated by the following percentage increases: chlamydia 49%, gonorrhoea 52%, and HIV/AIDS episodes 56%. The GUM clinic is cramped in the face of these demands, presenting the need for more space, privacy, and efficiency. As will be appreciated throughout this report, there are now demands for GUM to outreach into the Walsall community and to support primary care. All these demands arise at a time of priority need not only for a second GUM consultant but also more support staff to sustain the quantity and range of activities.

The national strategy has now been adapted into a Walsall strategy to address the sexual health agenda across the borough. It is informed by a wide range of stakeholders who have contributed to a number of innovative projects. For example, one active group tackling unintended teenage pregnancies has faced a massive challenge since Walsall's rates have been significantly higher than the regional and national average. Conception rates for ages 15-17 years from 1995-1997 were 62.2 per 1000 women, with only Sandwell at 67.8 having a higher rate in the region. However, the group may be rewarded for its efforts since more recent trends suggest a decline in teenage conceptions that, hopefully, can be sustained.

A different picture emerges for pregnancy ending in termination. Recorded rates of termination in women aged 11-15 and 16-19 years in Walsall were similar to the regional and national level from 1997-1999. However, percentage of conceptions for ages 15-17 years leading to terminations was markedly lower than elsewhere in the region. This may reflect medical, political, or cultural beliefs in Walsall, but access may be an important factor. Abortion figures in 2001 showed that eight of the 13 health authority areas of the West Midlands had higher than average NHS terminations performed at 13 or more weeks of gestation. The national average was 13.4% but Dudley and Walsall were the highest in the country for late abortions at 23.9% and 23.7% respectively. Clearly we need to do more to ensure that women who meet legal requirements access an abortion within the recommended three weeks of first appointment with the referring doctor.

The key to improving access to services lies in level 2 delivery in primary care of integrated GUM and Family Planning (FP) services strategically located at GP centres across the borough. These services include screening and treatment of STIs, vasectomy, and intrauterine device insertion. We will need incentives for GPs to take on training associated with GUM and FP accreditation. A consultant in Community Gynaecology will be needed to liaise with the Manor and oversee many of these access and integration issues in Walsall. Otherwise, activities are already in place to deliver on the national strategy and meet targets.

Examples of such activities include the teenage 'one stop' sexual health clinic, and established schools programmes where specialist workers deliver education on FP and sexual health. There is a dedicated Men's Health project that caters for the gay and bisexual community. Another project addresses health and social needs of commercial sex workers, mainly engaged in street prostitution. This is a reminder that young, including under-age, women are frequently coerced into unwilling activity, too often to feed a partner's drug habit. This report will provide several examples of socially excluded and disadvantaged groups in Walsall who deserve more. Delivering well on sexual health will certainly do much to address inequalities, one of the linchpins of public health.

This report on sexual health in Walsall attempts to present the human dimension, based around the first three of four chapters. Chapter 1 considers young people, Chapter 2 women, and Chapter 3 men. Thus, the STIs feature throughout with different emphases. At the end of each chapter is a summary of where we are and where we need to do more in Walsall according to national strategy expectations. Following each chapter is an illustrative patient pathway which shows the often distressing nature of sexual ill health. Chapter 4 is an inevitable focus on GUM and FP services, again ending with a structured summary. Finally, the report ends with a conclusions section that presents an executive summary of key points, important messages, and recommendations.

YOUNG PEOPLE

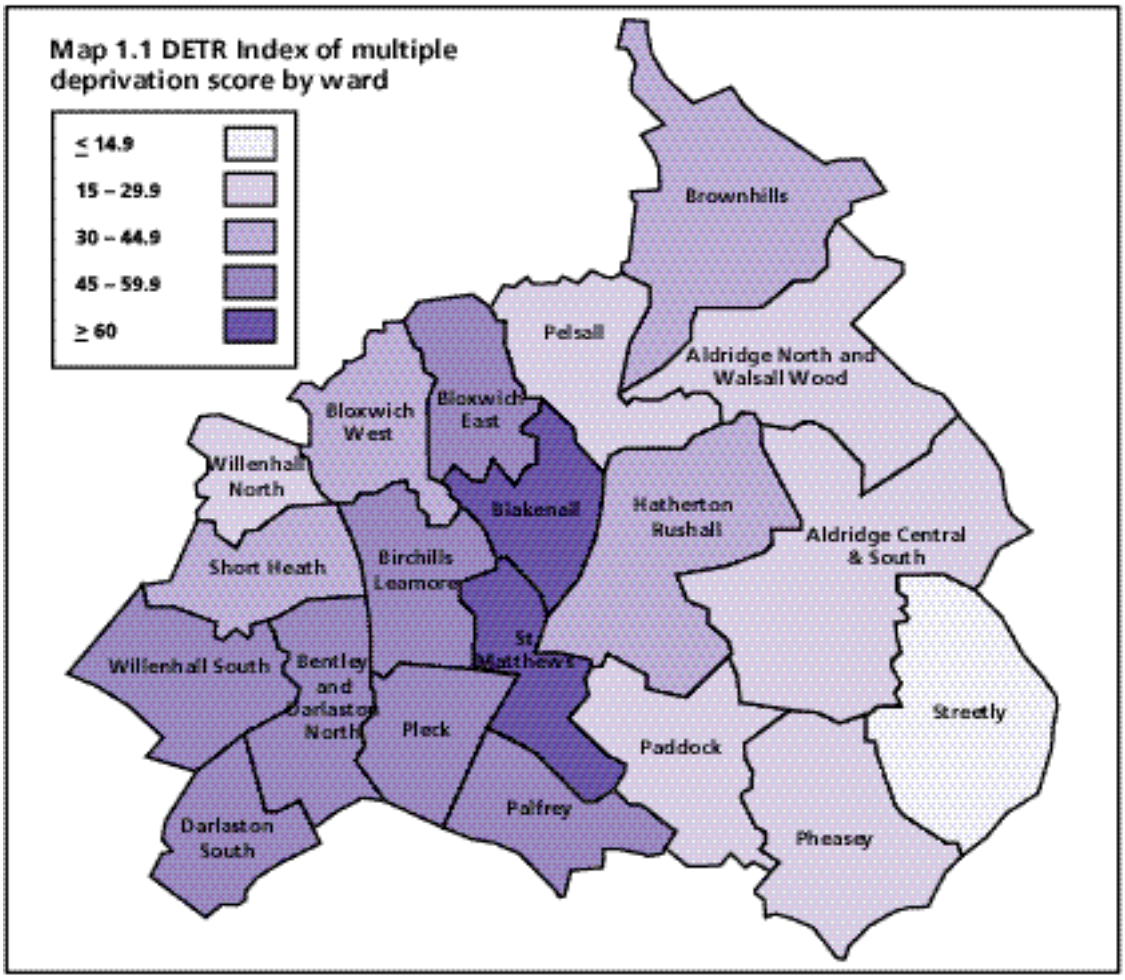
Approximately a quarter of a million people live in Walsall, with the densest population occurring in the north, west and south of the borough in close proximity to the M6 motorway. The south-west has a high ethnic minority population, largely South Asian, with a youthful age profile. Wards located in the west and centre, along a north-south axis, are more deprived than those in the east and are associated with poorer health outcomes **(Map 1.1)**. These include higher rates for teenage pregnancy and sexually transmitted infections (STIs), higher unemployment and lower educational standards.

Young people, age 19 years and younger, account for approximately 27% of the population of Walsall. That represents around 68,000 from a total population of approximately 253,500. Details are provided in the 2002 Annual Report devoted to children **(1)**. There were links with deprivation in that children under 16 years as a proportion of the total population in each ward ranged from a low of 17% in the less deprived Paddock and Pheasey, to over 25% in the more deprived Blakenall, Palfrey, Birchills Leamore, and St Matthews. Again, the more deprived wards had the highest proportion of births to one-parent households, with Blakenall the highest at 29% (compare Pheasey 2% and Streetly with none). While around 14% of Walsall's population are from ethnic minorities, this rises to around 19% when considering primary school children. Since this chapter is concerned with sexual health, a prime interest is in teenagers. **Table 1.1** shows that approximately 34,000 teenagers reside in Walsall, representing 13% of the population.

Table 1.1 Walsall resident population 2001 Census, by age group

	Persons	Males	Females
All ages	253,502	123,244	130,258
1-4	16,431	8,323	8,108
5-9	17,488	8,767	8,721
10-14	17,626	8,967	8,659
15-19	16,200	8,285	7,915
0-19 years	67,745	34,342	33,403
% 0-19 years	26.7	27.9	25.6

Source: Office for National Statistics



Source: Department of the Environment, Transport and the Regions, Indices of Deprivation 2000

Pregnancy

You can't get pregnant the first time you do it... and... You can't get pregnant if you do it standing up... are two common myths still circulating among young people almost 20 years after it became acceptable to teach sex education in schools. In spite of continuous efforts to improve the quantity and quality of school-based sex education, the rates of teenage pregnancy in Walsall remain stubbornly high. However, in the last 3 years the rates in both the under 16 age group and the under 18s has declined steadily, in line with national trends **(Table 1.2, Figure 1.1)**. A Walsall teenage pregnancy strategy is in place to capitalize on this success **(2)**. Note that the proportion of conceptions leading to abortion is increasing, although lagging behind elsewhere. Patterns of teenage pregnancy in Walsall over the last 7 years show that early pregnancies occur most frequently in deprived areas of the borough **(Map 1.2)**.

An analysis of Walsall's teenage mothers in 1999 showed that the majority of girls:

- ❑ were entitled to free school meals
- ❑ were from families receiving benefits
- ❑ were of average or below average ability
- ❑ had poor school attendance records
- ❑ came from families with a history of early pregnancies **(3)**

Other risk factors for early pregnancy included:

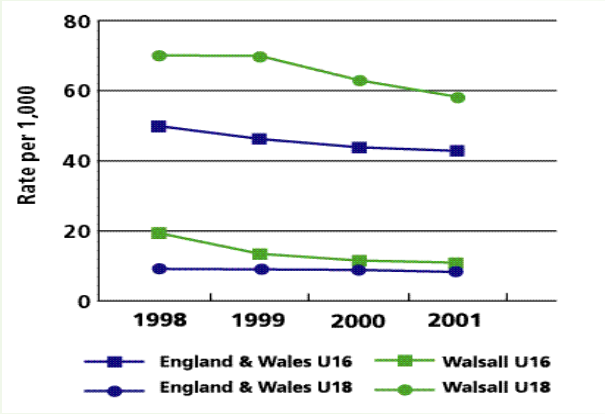
- ❑ children in foster care
- ❑ children in the care of the local authority
- ❑ engagement in the sex industry
- ❑ tendency to offending

Again, these factors are all associated with deprivation and social exclusion.

Table 1.2 Conceptions in under 18's, rate per 1000 women aged 15-17, and percentage of conceptions leading to termination for Walsall, West Midlands and England and Wales, 1998-2001

		England and Wales	West Midlands	Walsall
1998	No. of conceptions	44,119	5,085	326
	Conception rate	47.6	51.9	68.4
	% leading to termination	42.0	41.0	27.0
1999	No. of conceptions	42,028	4,838	323
	Conception rate	45.8	49.8	68.4
	% leading to termination	43.1	40.7	31.0
2000	No. of conceptions	41,339	4,859	306
	Conception rate	44.1	49	62.7
	% leading to termination	44.2	43.0	35.0
2001	No. of conceptions	40,966	4,759	289
	Conception rate	42.5	46.8	57.1
	% leading to termination	46.0	45	36.3

Figure 1.1 Conception rates in under 16's (per 1000 women aged 13-15) and under 18's (per 1000 women aged 15-17) for Walsall and England and Wales, 1998-2001



Source for conception numbers and population estimates: Office for National Statistics (rebased rates using 2001 Census population estimates for 1998-2001)

Pregnancy and abortion

Note the trend in Table 1.2. While the conception rate is decreasing in Walsall, the proportion of pregnancies resulting in termination is increasing. This recent change may be an adjustment factor in contributing to the increase in late presentations for termination of pregnancy.

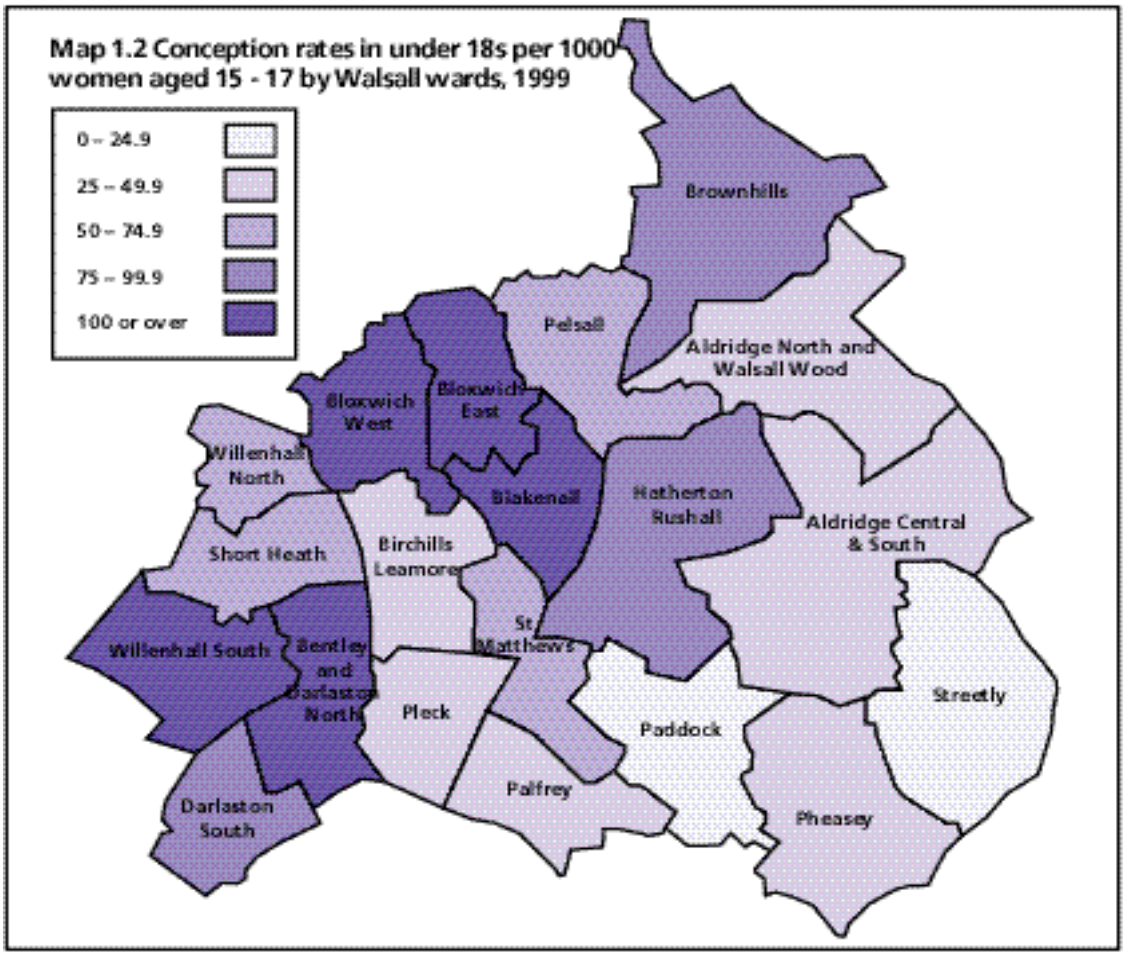
Alcohol

Binge drinking is increasing among young people. As a result, teenage girls and young women are especially vulnerable to sexual exploitation and rape.

A Social Exclusion Unit report showed that:

- ❑ after uncontrolled drinking, 1 in 7 older teenagers go on to have unsafe sex
- ❑ a survey of 13 and 14 year olds revealed 40% were drunk when they experienced first intercourse
- ❑ 21% of 11-15 year olds now drink on a regular basis
- ❑ this age group's average weekly drinking rose from 5.3 to 9.9 units per week between 1990 and 1998 **(4)**

In Walsall, a Schools Health Education Unit 2001 survey found similar and disturbingly high levels of alcohol consumption in 9-15 year olds.Schools education now addresses alcohol as well as drugs. The police and local authority are tightening up on under age drinking and purchasing alcohol.



Source: Office for National Statistics (rates calculated using 1999 adjusted ward population projections)

Abortion

Details on teenage pregnancy are also provided in the 2002 Annual Report but it is worth restating data on termination of pregnancy **(1)**. Recorded rates of termination in women aged 11-15 and 16-19 years in Walsall were similar to those seen at regional and national level between 1997 and 1999 **(5)**. However, in the 15-17 year age group, numbers of terminations as a percentage of conceptions presents a different picture **(Figure 1.2)**. Walsall had a percentage of conceptions leading to abortions markedly lower than other West Midlands areas 5 years ago, although recently it has begun to catch up. This may have reflected medical, political, or cultural beliefs in Walsall's population. **Table 1.3** shows a deteriorating situation in that the proportion of late terminations (at 13 or more weeks gestation) is increasing, eg each year from 1998, 12.9% compared to 17.2% nationally, to 2001, 25.5% compared to 13.9% nationally. The earlier the termination, the less the health risk to the woman.

Figure 1.2 Percentage of conceptions leading to termination, Birmingham and Black Country, women aged 15 - 17, 1996 - 1998 and 1999 - 2001

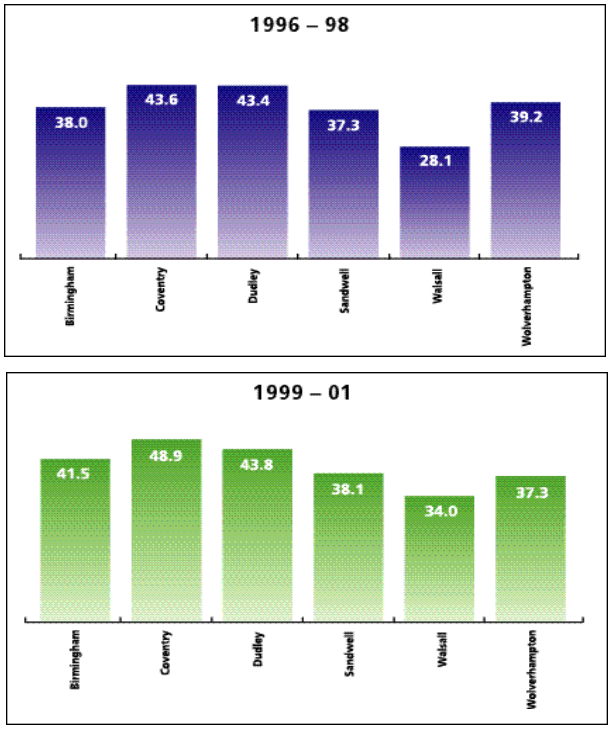


Table 1.3 Legal Abortions: under 18's by weeks gestation, Walsall and England and Wales, 1998-2001

Year	Area	Total	NHS	Non-NHS	%NHS	Less than 13weeks	13 weeks or more	%13 weeks or more
1998	England & Wales	17,220	15,313	1,907	88.9	14,253	2,967	17.2
1998	Walsall	85	75	10	88.2	74	11	12.9
1999	England & Wales	16,619	14,863	1,751	89.4	13,753	2,866	17.2
1999	Walsall	86	71	15	82.6	72	14	16.3
2000	England & Wales	17,129	15,436	1,693	90.1	14,123	3,006	17.5
2000	Walsall	90	75	15	83.3	69	21	23.3
2001	England & Wales	17,296	15,849	1,447	91.6	14,893	2,403	13.9
2001	Walsall	98	87	11	88.8	73	25	25.5

Source: Office for National Statistics (complete data before 1998 unavailable)

Condom use

As well as the risks that young women face of pregnancy from having unprotected sex, they also face high risks from contracting sexually transmitted infections (STIs). First sexual experiences are often unplanned and opportunistic, and the use of condoms or other forms of contraception is infrequent. Poor negotiating skills for both girls and boys mean that the subject of contraception is rarely discussed and many young people cite difficulties or embarrassment in being able to obtain free condoms.

A recent survey of 14-15 year old pupils showed that 77% of girls and 54% of boys in Walsall knew where they could obtain free condoms, compared with the national sample of 53% and 42% respectively. This increased awareness followed the appointment of a Family Planning (FP) trained nurse who visits most Walsall schools delivering lessons in contraception as part of the schools' Sex and Relationships Education programmes. Visits by young people to the principal FP unit at the Hatherton Centre in Walsall increased after the nurse had been into schools, emphasizing the need to provide services that young people can be confident in accessing. A known, friendly face is often a key feature in establishing this confidence.

Emergency contraception

The morning-after pill is normally effective if taken less than 72 hours since unprotected sex. A progesterone-only emergency contraceptive became available in the UK in 2000. This comprises two tablets of 750mg of levonorgestrel taken 12 hours apart. The method delays or inhibits ovulation and does not induce abortion since it acts before implantation of the fertilized ovum.

Condom use and oral sex

Male condom use is central to the practice of safe sex, both in preventing pregnancy (85-99% efficacy) and protecting against STIs. Young people must be taught how to use condoms safely and effectively.
Demonstration of condom use is now part of sex education courses. It is important to emphasize that STIs, including HIV, can be transmitted by oral sex. Oral lesions (eg of syphilis and genital herpes) are well known. Condom use for oral sex is protective **(8)**.

The 2000 National Survey of Sexual Attitudes and Lifestyles showed that average age of first intercourse fell over a decade from 17 to 16 years and that the lifetime number of sexual partners for both men and women increased **(6, 7)**. Risk taking behaviour also increased, with inconsistent use of condoms and increased anal intercourse (up from 7% of men and 6.5% of women in 1990 to 12.4% of men and 11.3% of women in 2000). The Genitourinary Medicine (GUM) adviser who works with young people in Walsall schools reports that young people are increasingly likely to consider anal sex or oral sex as an alternative to vaginal penetrative sex, believing they are less risky practices. The influence of peers, the media, and an increased openness about sex generally seem to have influenced these changes.

Sex education in Walsall schools

A FP nurse and GUM health adviser visit most schools to provide dedicated education on contraception, STIs, HIV, and how to access services. However, there are some schools which do not permit this on religious and cultural grounds.

Sexually transmitted infections

Increased awareness of contraception and the need to protect against unplanned pregnancies is in sharp contrast to awareness of STIs. In the early 90s, there was a large government sponsored campaign to raise awareness of the dangers of the human immunodeficiency virus, better known as HIV. All schools in Walsall were provided with resources to teach about the threat of this virus and the national campaign meant that awareness of the dangers of unprotected sex was at a high. The Lifestyle Survey undertaken in 2000 showed that Walsall pupils' knowledge of HIV and its methods of transmission was sketchy, but 77% of pupils aged 14-15 years knew that HIV could be transmitted by having sex without using a condom, compared with 82% of the wider population **(6, 7)**. Other national surveys have shown the same trends.

There has been a dramatic rise in incidence of STIs in the general nationwide population over the last 10 years. Cases of Chlamydia and gonorrhoea have more than doubled in the last 6 years and this is the case in Walsall. **Table 1.4** and **Figure 1.3** show these trends, along with those for genital herpes and genital warts (syphilis and HIV will be discussed in the following chapters). All four infections predominantly affect young people: older teenagers and those in their 20s, when sexual activity is at a peak **(Figure 1.4)**. Chlamydia is the most frequently detected STI nationally, but many young people have never heard of it. The infection is asymptomatic in around 70% of females and 50% of males. Left untreated in females, it can cause pelvic inflammatory disease (PID), ectopic pregnancy, and infertility.

Examining **Table 1.4** and **Figure 1.3**, the marked increasing trend for Chlamydia and gonorrhoea is reflected in Walsall, at regional and at national level. The increase in gonorrhoea among males is marked in Walsall, where male cases exceed female cases, as in this region and nationwide. Homosexual activity accounts for this excess of gonorrhoea cases among males. Rising trends in genital herpes and genital warts have also occurred. Both tend to predominate in females early on before increasing in frequency with age among males.

Much of the focus on preventing teenage pregnancy and on taking responsibility for sexual health is often directed at females but, as the Social Exclusion Unit's 2000 report into Teenage Pregnancy states: Young men are half the problem and half the solution. This statement is highly relevant since significantly more teenage girls than boys in Walsall are aware of the various routes of HIV transmission and how to protect against infection **(6, 7)**. For the last 2 years, there has been a specially trained health adviser visiting schools to provide dedicated lessons on STIs, HIV, and, most important, information on where young people can access services if they think that they may have picked up an infection from having unprotected sexual intercourse.

Table 1.4 Number of cases of sexually transmitted infections, Local, Regional and National Trends, 1996-2002

Chlamydia						
Year	England		West Mids		Walsall	
	F	M	F	M	F	M
1996	18,526	13,946	1,204	1,305	68	58
1997	22,659	16,180	1,735	1,443	60	47
1998	24,975	18,937	2,048	1,657	41	30
1999	29,196	21,808	2,385	2,083	129	87
2000	34,815	26,632	2,827	2,309	146	104
2001	38,248	29,166	2,820	2,378	147	102
2002	–	–	–	–	193	157
Uncomplicated Gonorrhoea						
Year	England		West Mids		Walsall	
	F	M	F	M	F	M
1996	3,977	7,911	498	775	20	39
1997	3,981	8,418	450	772	16	33
1998	4,089	8,446	401	643	19	48
1999	4,880	10,677	501	952	19	45
2000	6,225	14,290	669	1322	39	67
2001	6,642	15,479	783	1504	49	98
2002	–	–	–	–	72	214
Anogenital Herpes simplex - 1st attack						
Year	England		West Mids		Walsall	
	F	M	F	M	F	M
1996	9,453	5,755	723	459	49	39
1997	9,482	5,597	758	435	49	36
1998	9,675	6,140	746	390	52	35
1999	9,852	6,039	679	450	46	35
2000	9,976	6,190	756	472	61	39
2001	10,558	6,492	804	491	74	43
2002	–	–	–	–	101	84
Anogenital warts - 1st attack						
Year	England		West Mids		Walsall	
	F	M	F	M	F	M
1996	27,583	27,113	2,003	1,951	138	114
1997	28,472	30,239	2,113	2,162	135	112
1998	28,899	30,782	2,102	2,107	117	115
1999	29,322	31,908	2,065	2,209	111	117
2000	28,711	32,067	2,086	2,319	95	134
2001	29,568	32,636	2,060	2,099	161	163
2002	–	–	–	–	195	190

Source: England PHLS. West Midlands and Walsall 1996-2001 West Midlands Sexually Transmitted Infection Surveillance Project; 2002 Walsall GUM clinic

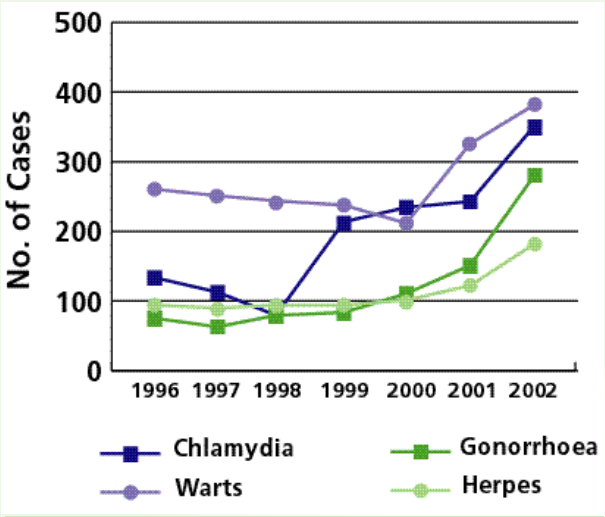
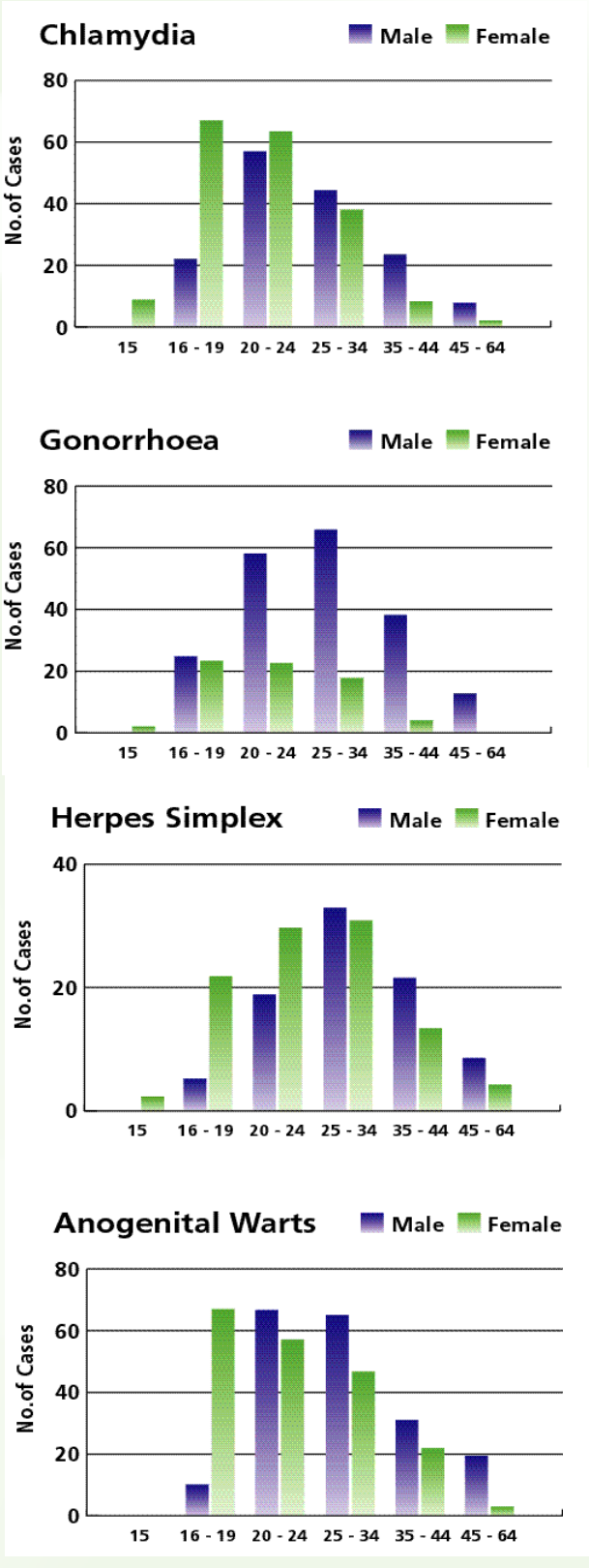


Figure 1.3 Number of cases of sexually transmitted infections in Walsall, 1996-2002
Source: West Midlands and Walsall 1996-2001 West Midlands Sexually Transmitted Infection Surveillance Project; 2002 Walsall GUM clinic

Figure 1.4 Number of cases of sexually transmitted infections by age group, Walsall GUM Service, 2002
Source: Walsall GUM Service



Four leading STIs in the UK

Gonorrhoea, caused by the bacterium Neisseria gonorrhoeae, infects the genital tract including the urethra and in women the cervix and the fallopian tubes. It can also infect the rectum, oropharynx, and the eye. Transmission is more efficient from male to female. Men usually develop symptoms (due to a longer urethra) while in women cervical infection is asymptomatic in 70% of episodes. Causes the range of complications described for chlamydial infection but can also spread widely to cause eg meningitis and endocarditis. Responds to antibiotics but resistance is increasing.

Chlamydia trachomatis genital infection is the most common bacterial STI in the developed world, affecting 3-5% of sexually active young women. Prevalence is lower in men. It is associated with age under 25 years, a new sexual partner or more than one sexual partner in the recent past, lack of barrier contraception, use of the oral contraceptive pill, and termination of pregnancy. This underlines the importance of accurate screening and diagnosis. Responds to drugs such a doxycycline or azithromycin.

Genital herpes simplex virus (HSV) is the most common ulcerative STI in the UK. Primary HSV is usually severe with intensely painful lesions, often worse in women and homosexual men. A distressing STI that tends to recur even after antiviral treatment.

Genital warts are caused by certain types of human papillomavirus (HPV), some of which are linked to cervical cancer. The most common STI diagnosed in UK GUM clinics, treatment can be very limited and recurrences are common.

Initiatives

A range of initiatives are in place to raise awareness of sexual health and enable intervention in Walsall.

Young fathers

The strategy to reduce teenage pregnancy rates in Walsall has initiated some research into the profile of young fathers in Walsall. The average profile is of fathers in their late teens and early twenties who are often very proud to be fathers and very much want to be involved in the care and upbringing of their babies. The reality is that their relationship with the young mother frequently breaks down and they feel excluded from the process from an early stage in the pregnancy, with health professionals and often the girl's family preventing them from being as involved as they would like to be.

Sure Start Plus

The introduction of this government initiative, aimed at supporting teenage parents and encouraging young mothers back into education and training, has resulted in some positive work to engage young fathers in activities such as the teen clubs in Blakenall and Brownhills that are designed to attract both mothers and fathers to take part in enjoyable activities that help them with parenting skills. The presence of a variety of health professionals and the teenage pregnancy advisers has enabled young fathers to be actively involved with their child's upbringing.

Health Action Zone

A very effective way of engaging with young people is through arts work. Walsall's designation as a Health Action Zone has facilitated a range of innovative ways of consulting and involving people in identifying their health needs and improving services. The research into young fathers led to the production of a piece of drama called Ben, Nat and Baby Jack which explores the issues of early parenthood. This drama production has toured Walsall Secondary schools.

Walsall conservatism

Walsall has not been so proactive as other boroughs in providing young people friendly sexual health services such as emergency contraception, free condoms, and early access for termination of pregnancy. It is clear that many initiatives are not acceptable at all to a significant proportion of society. It is often necessary to move things gradually.

One-stop shops

Reluctance to access health services is not just an issue for young Asian people but is common to many groups of young people. Information about sex and related topics comes mainly from peers and the media. Although many young people say that they would prefer to receive such information from their parents, the reality is that many parents are still reluctant to talk to their children about sexual health issues. There is a national move to provide young people friendly sexual health services. Walsall has not been as proactive in this area as other boroughs and there is still very patchy coverage for services such as access to:

- ❑ free condoms
- ❑ the 'morning-after' pill (emergency contraception)
- ❑ early termination of pregnancy for those who wish to choose this option

Until recently, the opening hours of the GUM clinic were not young people friendly, but the introduction of a new service which runs immediately after the contraceptive service for young people at the Hatherton Centre has steadily seen an increase in its usage by older teenagers. The presence in schools of both the GUM adviser and the FP nurse has meant that young people feel more confident to use the service. Other models of youth provision are planned for the borough in settings that are not necessarily medical. The Electric Palace in Bloxwich offers confidential information, advice and support on a range of health issues, as well as free condoms and pregnancy testing. There are plans to train health professionals, youth workers and Connexions Personal Advisers to be able to advise young people on sexual health matters and refer them into appropriate services where they can receive professional help and support.

Parents

Parents must play a key role in supporting their children to become sexually aware adults. They should make them aware of the risk they face from early sexual experimentation and from having multiple partners. The guidance to schools on teaching about sex and relationships education places responsibility on the school to engage with parents on this issue. There will also be a series of short programmes offered to help those parents who wish to talk to their children about sexual health but lack the confidence and skills to do so.

Walsall's sexual health strategy

In July 2001 the Department of Health issued a consultation document on the first national strategy for sexual health and HIV **(9)**. The response, along with an implementation plan, was produced in June 2002 **(10)**. All Primary Care Trusts were expected to develop their own local strategies by April 2003, based on the national recommendations. Walsall duly complied **(11)**. The strategy focuses on developments in two key areas to provide and enable better sexual health:

A. BETTER PREVENTION
B. BETTER SERVICES

Aims of the strategy

- ❑ Reduce transmission of HIV and STIs, with a national goal of achieving a 25% reduction in newly acquired HIV and gonorrhoea infections by 2007
- ❑ Reduce prevalence of undiagnosed HIV and STIs along with the national standard that all GUM services offer the HIV test to clinic attendees on first screening for STIs, and with working towards shorter waiting times for urgent GUM appointments
- ❑ Reduce unintended pregnancy rates, including setting the national standard that women meeting the legal requirements should have access to an abortion within 3 weeks of first appointment with the referring doctor
- ❑ Improve health and social care for people living with HIV
- ❑ Reduce stigma associated with HIV and STIs

Key elements and targets have been noted, particularly:

- HIV testing to be encouraged, including all attending GUM clinics
- targets to reduce HIV and gonorrhoea incidence by 2007
- improved access to GUM services
- closer working between primary and secondary care with single commissioning
- better access to NHS terminations of pregnancy
- enhanced hepatitis B immunisation of those at risk, eg gay men and drug injectors
- targeted Chlamydia screening to include all women attending GUM, receiving terminations of pregnancy, and having their first cervical smear

Actions relating to young people
A. BETTER PREVENTION

The following are key areas of where we are and where we need to be in Walsall:

1. The Teenage Pregnancy Media group needs to be broadened to include sexual health, linked to the wider PCT strategy on maximizing publicity, to also sustain the arrest and reversal of teenage pregnancy trends. There are strong links with a number of media outlets, including Walsall FC.
2. The Sex and Relationships Education (SRE) spearheaded in secondary schools by our FP nurse and GUM adviser is being further sustained by assisting teachers to plan and deliver SRE.
3. A project is underway to improve SRE among special schools, in partnership with Wolverhampton.
4. A resource for teaching SRE at Key Stage 2 has been produced and the coverage (already 52%) of Walsall schools working to national standards needs to be continually increased.
5. FPA courses have been commissioned for everyone working with young people and the programme to accredit teachers and school nurses to become specialist teachers in SRE is being extended.
6. Walkways and Walsall Pregnancy Help offer counselling and advice on termination of pregnancy, complemented by improving access to emergency contraception through pharmacists.
7. Two teenage pregnancy advisers working for Sure Start Plus have developed protocols for other advisers on condom use by under 16s.
8. Foster carers have received training on sex and sexuality and new guidelines on SRE are being developed for them and also social workers.
9. More work needs to be done involving parents through schools, and more work with young men regarding condom use.
10. More work needs to be done, with appropriate targeting, for special young people groups, eg from ethnic minorities, those with learning disabilities, young offenders, returning prisoners, asylum seekers, and the homeless.

Other actions appear in Chapters 2 and 3; also in:

B. BETTER SERVICES (Chapter 4).

What if my parents find out?

Tracey and Jay have been going out together for about six months. They have known each other since Primary School and their families are good friends. Jay has just finished his GCSE's but Tracey is in the year below him at school. At an end of term celebration, Jay and Tracey are drinking alcohol and are offered the chance of a sleep over at the party. Tracey's parents agree that she can stay and that her father will collect her the next morning.

Jay has had unprotected sex with two other girls in the last year and sees no reason to tell Tracey about this. He really likes Tracey and wants to have sex with her. She is more reluctant but has had enough to drink to not think of the consequences, so he finds an empty bedroom and they make love. Neither of them has planned to do this and they never discuss the use of condoms.

A few weeks later, Tracey misses her period and starts to realise that she may be pregnant. She becomes very frightened and doesn't know what to do. Tracey knows that her parents will be very angry so she feels she can't talk to them. She thinks about going to her GP but is afraid that her parents will find out. Talking to a teacher is a possibility, but she thinks that they will tell her parents anyway. The school nurse comes into school, but you have to ask a teacher if you can see her. She doesn't know what other options she has so she tries to ignore the issue altogether.

Jay, in the meantime, has been contacted by a health adviser from the GUM clinic. One of the girls he has slept with has Chlamydia and he has to go to GUM to be tested. He has been asked to give the names of anyone else he has had sex with so that they can also be contacted and tested. He thinks of Tracey and doesn't know what to do.

Help and Advice:

Free pregnancy testing:

- The Hatherton Centre, Hatherton St., Walsall 01922 775041
- GUM Clinic 01922 633341
- Walsall Pregnancy Help, Deaf Centre, Walsall 01922 649000

Emergency contraception:

- The Hatherton Centre 01922 775041
- GUM Clinic 01922 633341
- General Practitioner
- Pharmacies in Walsall taking part in a pilot emergency contraceptive scheme
- NHS Walk In Centre, Walsall 01922 858535

To talk to someone:

- The Hatherton Centre 01922 775041
- GUM Clinic 01922 633341
- Walsall Pregnancy Help 01922 649000
- WALKWAYS Youth Counselling Service 01922 615393
- Brook Clinic, Birmingham 0121 643 5341
- Sure Start Plus Advisers 01922 6562099
- General Practitioner
- School Health Adviser
- Electric Palace 01922 477499
- Parents

On keeping the baby:

- The Sure Start Plus team 01922 652099

On terminations:

- Your GP who will refer to the Hatherton for pre-abortion counselling
- Self refer to the Hatherton Centre 01922 775041
- GUM Clinic 01922 633341
- Walsall Pregnancy Help 01922 649000
- Brook Clinic, Birmingham 0121 643 5341
- For women less than 9 weeks pregnant there is the option to have a medical termination at the Manor Hospital. After 9 weeks a surgical termination would be offered. The earlier a termination is performed the better the health outcome for the mother. Very late presentations for termination carry much greater health risks.

For free condoms:

- The Hatherton Centre 01922 775041
- GP practices taking part in the condom distribution scheme
- The Electric Palace 01922 477499
- Walsall Pregnancy Help 01922 649000

Sexual health in women includes important issues around pregnancy. Women may be particularly vulnerable and have specific sexual health needs. They include commercial sex workers, and victims of sexual abuse and rape. First, there are important links between STIs in women and cervical cancer.

Cervical cancer

Cervical cancer is both a preventable and curable disease, especially if identified at an early stage.

Human papillomavirus (HPV)

Changing attitudes and behaviours are a factor in the increasing rates of STIs. HPV infection is one of the most prevalent STIs worldwide, affecting up to 75% of sexually active women. There are nearly 100 types of papilloma virus. Some target the hands and feet resulting in the common wart while others are sexually transmitted, resulting in genital warts.

The number of women in Walsall with genital warts has almost doubled in the last 2 years **(Figure 2.1)**. This gives cause for concern as certain types of genital HPV (types 16 and 18) are associated with cervical cancer. At present there is no vaccine that can prevent HPV infection and so the most reliable way to avoid infection is to use a condom and reduce exposure to the virus by reducing the number of sexual contacts.

Cervical cancer screening

The NHS cervical screening programme aims to reduce the number of women who develop invasive cervical cancer and the number of women who die from it. Screening identifies changes in the cells of the cervix before they develop into cancer. These cells can then be removed quickly and easily in most cases. All women aged between 20 and 64 years are automatically invited for screening. In Walsall, women are invited to screening every 3 years.

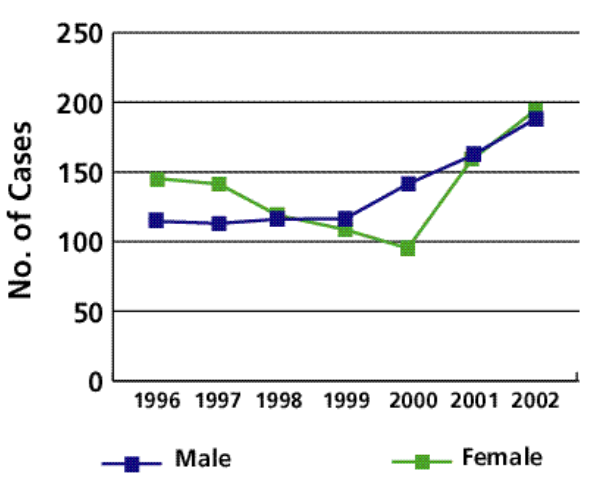
Cervical cancer has declined since introduction of cervical screening in 1988. Screening saves an estimated 1,000 lives per year and prevents up to 3,900 cases of cancer a year **(12)**. **Figure 2.2** shows the decreasing incidence and mortality from cervical cancer in Walsall from 1981 to 2000.

REDUCING RISK

Risk of cervical cancer is reduced by:

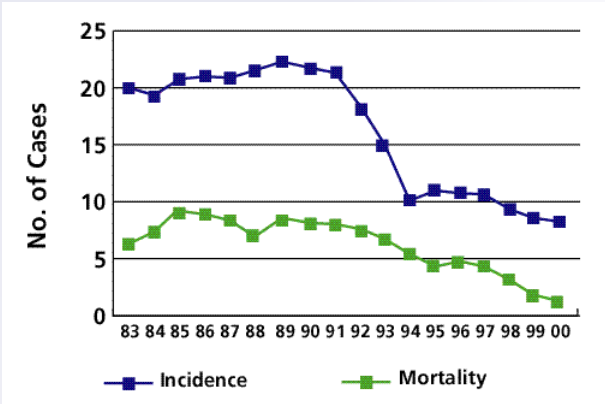
- ❑ safe sexual practices to reduce the chances of acquiring a sexually transmitted infection
- ❑ attendance for cervical screening.

Figure 2.1 Anogenital warts (1st attack) in Walsall, 1996-2002



Source: West Midlands Regional HIV Surveillance Project

Figure 2.2 Cervical cancer incidence and mortality (directly standardised rate per 100,000 population, and 3 year rolling averages up to dates listed) 1981-2000, Walsall



Source: West Midlands Cancer Intelligence Unit, Cancer Information Service

Cervical screening in Walsall

Cervical screening in Walsall carries a tremendous workload, serving an eligible population of around 75,000 women. The Walsall Manor Hospital is the main provider of cytology, colposcopy and histology services to the local screening programme.

Primary care staff play an important role in the screening programme. Of the 22,551 cervical smears analysed during 2001/2002, 86% were taken in general practices within the borough. The Walsall Primary Care Cervical Cytology Group is charged with developing and improving screening within primary care. Training and education of primary care

practitioners has been high on the agenda. In 2002, in collaboration with Wolverhampton University, Walsall PCT devised a new educational programme for practice nurses involved in screening.

RISK FACTORS FOR EARLY CERVICAL CANCER

Cervical cancer is both a preventable and curable disease, especially if identified at an early stage. Studies have identified a number of factors that play a significant role in the development of CIN (cervical intraepithelial neoplasia), the pre-cancerous changes in cells that cervical screening aims to detect:

- ❑ Sexual activity before the age of 20 years
- ❑ Multiple sexual partners
- ❑ Exposure to sexually transmitted infection
- ❑ Mother or sister with cervical cancer
- ❑ Smoking
- ❑ HIV or AIDS

Cervical screening quality assurance

The local screening service is assessed against national standards as described in the Quality Assurance Guidelines of the Cervical Screening Programme **(13)**. Key findings were made for 2001-2002 **(14)**. They included:

- ❑ Coverage – refers to the proportion of eligible women screened for cervical cancer. Walsall is just above the national standard at 81.6%. The difficulties experienced with poor uptake of cervical screening in deprived areas and among minority ethnic groups persist. A survey amongst South Asian women in Walsall in 2001 found that a common reason cited for non-attendance at screening was a perception that they were not at risk **(15).**
- ❑ Notification of results to women – 85.3% of women received their smear result within the national standard of 6 weeks. This was the best performance in the West Midlands.
- ❑ Smears from women under 20 years – 0.8% (180 smears) of the laboratory workload was from women under 20 years. This is one of the lowest rates in the West Midlands and should be commended. These women are outside the age range for cervical screening.
- ❑ Colposcopy waiting times – the colposcopy service failed to meet the waiting time standards for women referred for colposcopic assessment and for informing women of their biopsy results. Action is being taken to improve this situation.

STIs and infertility

Pelvic inflammatory disease (PID), which is often characterised by lower abdominal pain, vaginal discharge and fever, is caused by ascending infection from the endocervix. STIs, particularly Chlamydia and gonorrhoea, are common causes. PID is an important condition because if left untreated it can result in infertility, chronic abdominal pain and ectopic pregnancy.

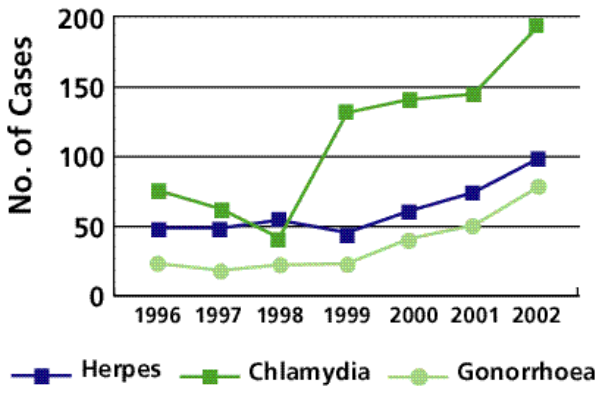
In Walsall, infections with Chlamydia increased dramatically over the last five years, mirroring regional and national trends, as was seen in **Table 1.4** of Chapter 1. Increasing numbers of infection have been seen in both men and women, with the biggest rise in women aged 16-19 years. Gonorrhoea and genital herpes also increased **(Figure 2.3)**.

Women with HIV are relatively few and mostly African, for which there is a special project described in the next chapter.

Fertility treatment

Consultants at the Manor Hospital run three infertility clinics, seeing approximately 220-270 new cases each year. Walsall PCT funds infertility treatment for certain groups; approximately 60 cycles of fertility treatment in 2001. Policy regarding the funding of infertility treatment is currently under review.

Figure 2.3 Sexually transmitted infections in women, Walsall residents, 1996-2002



Source: West Midlands Sexually Transmitted Infections Surveillance Project

Table 2.1 Abortion rates per 1000 women of maternal age

		11-15	16-19	20-24	25-34	35-39	40+
2000	England and Wales	2.30	26.70	30.90	17.40	8.90	1.80
	West Midlands	2.60	28.00	32.00	16.80	8.60	1.60
	Walsall	2.60	25.40	39.70	14.10	6.90	1.10
1999	England and Wales	2.20	26.00	29.90	17.30	9.00	1.80
	West Midlands	2.30	26.70	28.60	16.00	8.50	1.80
	Walsall	2.60	21.60	34.90	16.00	8.90	2.20
1998	England and Wales	2.40	26.50	30.40	17.80	9.20	1.80
	West Midlands	2.70	27.50	29.60	16.70	8.50	1.80
	Walsall	2.90	22.30	35.50	17.10	8.10	1.10
1997	England and Wales	2.20	24.40	29.00	17.10	8.70	1.70
	West Midlands	2.60	26.60	28.60	16.00	8.50	1.70
	Walsall	2.00	25.90	32.30	14.10	8.60	1.60
1996	England and Wales	2.32	24.30	28.53	16.54	4.00	
	West Midlands	2.68	25.64	28.29	16.26	4.10	
	Walsall	3.60	25.11	26.57	14.17	3.85	
1995	England and Wales	2.10	21.65	25.47	15.46	3.71	
	West Midlands	2.45	23.62	26.24	15.21	3.63	
	Walsall	3.02	24.24	27.79	16.00	3.43	
1994	England and Wales	2.09	22.02	25.40	15.62	3.73	
	West Midlands	2.39	23.04	24.99	15.73	3.76	
	Walsall	2.63	28.61	24.23	15.88	3.35	
1993	England and Wales	2.02	21.93	25.45	14.54	3.69	
	West Midlands	2.14	23.51	25.67	15.26	3.89	
	Walsall	1.73	22.59	26.08	14.79	3.99	
1992	England and Wales	2.02	22.31	18.96		3.61	
	West Midlands	2.46	24.74	18.90		3.70	
	Walsall	2.41	23.23	18.22		2.90	
1991	England and Wales	2.17	24.02	19.55		3.62	
	West Midlands	2.57	27.90	19.57		3.79	
	Walsall	2.59	26.46	15.87		3.10	

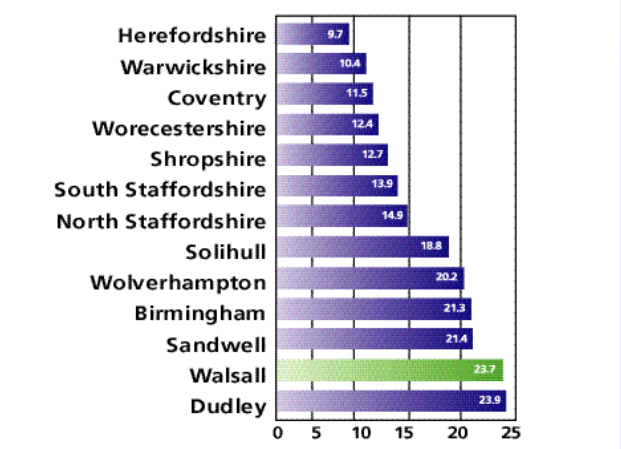
Source: Compendium of Clinical Indicators. Highlighted in green are Walsall rates which reflect those that exceed rates for the West Midlands.

Termination of pregnancy

Obstetrician and Gynaecologist Mr G Ward was instrumental in establishing local termination of pregnancy in 1981, emphasizing the importance of providing an accessible NHS funded service. The service in Walsall was one of the first in the country to offer termination using local anaesthesia, which the Royal College of Obstetricians and Gynaecologists recommended for the suction technique. Over the last 3 years the number of terminations for Walsall residents increased slightly: 88.8% performed in 2001 were carried out by the NHS.

Abortion rates were described among teenage girls in Chapter 1. **Table 2.1** shows abortion rates per 1000 by maternal age for all Walsall women. Note the highlighted Walsall rates that exceed those for the West Midlands. In particular over recent years in the 20-24 year age group, where Walsall rates are significantly higher, suggesting a recent demand for termination. This is relevant to the recent annual report of the Chief Medical Officer, which drew attention to the national variation in access to timely abortion **(16)**. Abortion statistics for England and Wales in 2001 showed that just under 88% of legal terminations were performed before 13 weeks of gestation. They also showed that 8 of the 13 former health authorities in the West Midlands had a higher than average percentage of NHS abortions performed on their residents at 13 or more weeks gestation. Walsall was amongst the highest in the country for late abortions with 23.7% **(Figure 2.4)**.

Figure 2.4 Percentage of terminations performed at 13 or more weeks gestation, West Midlands Region, 2001



Source: Office for National Statistics

A new service for medical termination was introduced in April 2003 with the aim of reducing local waiting times for termination of pregnancy. It was done so later than most areas because there were staffing and technical issues that needed to be in place. Further funding has since been provided to turn around the figures for late terminations.

MEDICAL TERMINATION OF PREGNANCY

This method is available only in the first 9 weeks of pregnancy when drugs are used to cause an early miscarriage. One works by blocking the action of the hormone that makes the lining of the womb hold onto the fertilised egg and the other given 48 hours later, causes the uterus to cramp. This requires two visits to a clinic on separate occasions, 2 days apart, plus a post abortion check a week later. The woman will first be given tablets of mifepristone, then spending the next 2 days carrying out usual activities at home or at work. Everyone is given a phone number that they can call at any time for advice. At the second appointment the woman is given prostaglandin, either as a tablet or vaginal pessary. This causes contractions in the uterus that may be quite painful. Clinic staff are able to give analgesia to help with the pain. At this stage the woman begins to bleed or, if the bleeding has already started, it is likely to increase. Usually within 6 hours or so the pain has settled, the bleeding is slight and the woman may leave the clinic. Most abortions take place during this time at the clinic but a follow up visit a week later is essential to ensure that it is complete. Some women choose an early medical abortion because it is more like a natural miscarriage and avoids any anaesthesia or the use of instruments.

Infection screening in pregnancy

Screening for infectious diseases in the antenatal period means that mothers can be treated and the risk of transmission to the foetus is reduced. In Walsall, at 16 weeks gestation, women are offered screening for hepatitis B, rubella, and syphilis. At the booking interview at 10 weeks, the midwife discusses HIV testing and other screening tests. Women are then tested for HIV at 16 weeks unless they decide to opt out of the screen.

Reducing mother to baby HIV transmission

In 2000, universal antenatal screening for HIV was introduced in Walsall, in line with government recommendations **(17)**. Antenatal HIV testing benefits both mother and child since:

- Detecting infection in the mother means that she can be offered appropriate treatment and advice about her own health and that of her unborn child
- The mother can make an informed choice about her pregnancy
- The use of HIV treatment, Caesarean Section, the avoidance of invasive procedures and of breast-feeding can significantly reduce transmission of infection to the baby **(18)**

Since antenatal screening started, 5 women have been diagnosed with HIV infection in Walsall. In January 2002, uptake of screening was 65%, rising to 83% by the end of the year (below target of 90%). It is the opinion of many that there should be a move toward routine screening of HIV. After all, how many mothers know that they are routinely screened for syphilis?

Reducing mother to baby hepatitis B transmission

It is now routine in Walsall that all pregnant women are offered antenatal screening for hepatitis B virus (HBV). HBV is a blood borne virus which can be transmitted from infected mothers to their babies at or around the time of birth. Babies acquiring infection at this time have a high risk of becoming chronic carriers of the virus. Such carriers, as well as being infectious to others, are at increased risk of later chronic liver disease and premature death from cirrhosis or liver cancer. Immunisation starting at birth can prevent around 90-95% of cases **(19)**.

SEXUAL HEALTH, WHO AND HEALTH INEQUALITIES

The World Health Organization states that sexual health is a state of physical, emotional, mental and social well-being related to sexuality.... Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The burden of poor sexual health is borne by women, gay men, teenagers and young adults from Black and ethnic minorities.

COERCION

It should be remembered that many a prostitute is forced into her trade by a partner and/or pimp at a very young age, usually to fund his drug habit. The victim becomes vulnerable to sharing his drug habit and her growing dependence serves to sustain work on the street or other commercial venues. Her inevitable social exclusion makes for challenging exit strategies and at the very least she deserves attention to health needs in the first instance.

Vulnerable women

Women with specific sexual health needs mainly include commercial sex workers, and victims of sexual abuse, rape or domestic violence.

Commercial sex workers (CSWs)

There are 90 women estimated to be working on the streets of Walsall, predominantly in the Pleck and Caldmore areas. This is higher than reported for Birmingham. A further 50 women operate from saunas, flats and brothels in Walsall. The majority are Walsall residents, white and between the ages of 18-26 (age range 15-45) years old **(20)**.

Street sex workers in particular are amongst the most marginalized members of our community. Often leading chaotic lives, these women have multiple health, social care and housing needs and are particularly susceptible to life threatening acts of violence. The majority find it difficult to access mainstream health and social care services.

The PCT currently commissions outreach health promotion services from SAFE, a specialist health provider. The outreach vehicle visits Walsall on two evenings every week. The project adopts a holistic approach to health promotion and harm reduction. It employs a health and community development worker, two drugs workers, a counsellor, a housing worker-mental health nurse and a midwife. Joint working with Addaction and Lantern House community drug teams means that the women have access to specialist support and a hepatitis B vaccine programme.

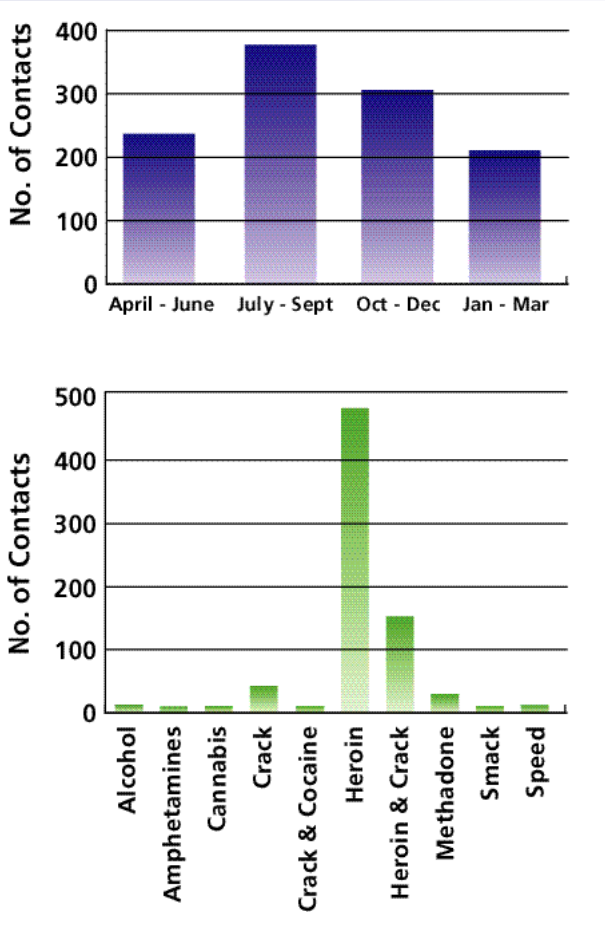
Between April 2002 –January 2003 10 street workers reported their age as between 15-18 years old. Many street workers start working before the age of 16 years. Ensuring that appropriate services, preventative strategies and good inter-agency working is aimed at tackling this issue is a local priority.

Figure 2.5 shows a seasonality of street contacts and high levels of drug use (SAFE 2001/02 data). The services provided by SAFE can be summarised as follows:

- exiting strategies
- condom and lubricant distribution
- sexual health information and advice
- liaison with and referral to a range of other agencies
- emotional support and practical help with any issues, eg courts, accompaniment to clinics
- discreet and confidential GUM and FP clinic and drop-in (Walsall and Birmingham).

Funding to SAFE was increased as a result of the community consultation research on prostitution in the borough in 2001, which showed that many residents are concerned about the women's welfare and see support services as vital **(21)**. Similar projects operate all across England. SAFE is a member of the UK Network of Sex Work Projects and Regional Network of Young People and Exploitation Projects.

Figure 2.5 Street contacts in Walsall with SAFE project, 2001-2002. Total 1,125 contacts distributed according to season and problematic substance misuse



Source: SAFE Project

KAREN'S STORY

Karen is 19 years old. She is addicted to heroin and uses crack cocaine. She started commercial sex work at the age of 16 years. SAFE outreach workers located and offered support after learning that she was pregnant and homeless. SAFE have tried to support Karen during the birth and have put her in contact with local health care services, housing and drug services.....

CSWs and STIs

During 2002, 3 cases of syphilis comprised a CSW (Commercial Sex Worker), her partner, and her newborn baby. On contact with GUM the CSW was 35 weeks pregnant, with no history of antenatal care and was asymptomatic although she had positive serology. She had between 25 and 30 regular male clients but only one non-paying regular partner. He presented with a large primary chancre on the penis and was IgM positive. He had casual sexual contacts 4 and 12 weeks previously with different female partners. The CSW delivered a baby girl at 37 weeks gestation. The infant had no congenital stigmata of syphilis, which is consistent with recent infection, but showed signs of liver and spleen enlargement, lack of blood platelets, and failure to thrive. She was treated with intravenous penicillin and taken into care. This cluster of cases is notable since congenital syphilis is rare indeed in the UK.

This case study is classical since studies consistently show a high rate of condom use in female CSWs, and relatively low risks of HIV and other STIs **(22)**. However, in this case (as is usual) the CSW's partner demanded unprotected sex to distinguish himself from her clients **(23)**. The reality is that CSWs are more vulnerable to STIs from their partners than they are from their clients.

Rape

Until recently there has been no rape crisis centre in Walsall. However, Crisis Point is a new organisation that aims to provide support and counselling to rape and sexual abuse victims and their families in Walsall. It opened its doors on a voluntary basis in 2003 and there is already a waiting list for its services.

A recent British crime survey showed that 1 in 20 women had been raped since the age of 16 years and 1 in 10 had experienced some form of sexual abuse. The same study showed that only 20% of rapes came to the attention of the police. The number of rapes reported in Britain has risen dramatically in the last 15 years, from 1,842 in 1985 to 7,809 in 1999.

RAPE IN WALSALL

Women are most likely to be attacked by men they know. It is estimated that 10 women a week are raped in Walsall. Only 20% of rapes come to the attention of the police.

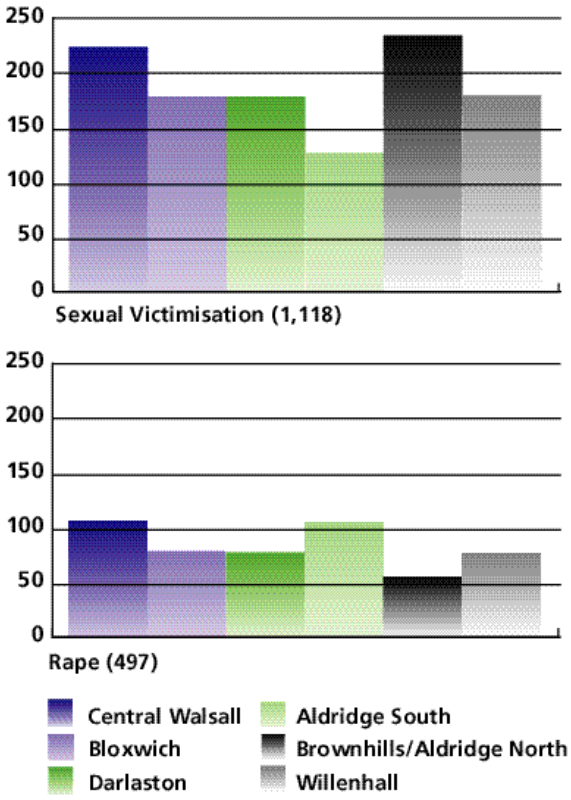
Crisis Point aims to provide:

- ❑ counselling and support to victims and families
- ❑ an exit strategy for persons from the sex industry
- ❑ training and education
- ❑ a safe retreat
- ❑ services to everyone
- ❑ excellence in service

The survey also found that women are most likely to be attacked by men they know. Current partners perpetuated 45% of rapes reported to the survey.

Crisis Point used this survey data, estimating that approximately 500 women are raped each year in the borough of Walsall: that is 10 assaults each week **(Figure 2.6).** Sexual abuse incidents are estimated to be above 1,000 a year. Around 10% of rape victims may be men who have been subjected to male rape.

Figure 2.6 Estimates of rape and sexual abuse incidents each year in Walsall (police areas)



Source: Home office extrapolated research data, 2003

Meetings are taking place to try and secure funding and start-up support for Crisis Point. There is a Manager and a potential Receptionist. Once funds and premises can be identified, there will need to be counsellors and support workers, supported by a Board of Trustees and Chief Executive.

SYPHILIS

This is a chronic STI that is systemic from the beginning and is characterized by florid manifestations and long periods of inactivity. The causative agent is Treponema pallidum, a delicate, spiral organism related to non-venereal forms found in certain developing countries. Both congenital and acquired syphilis are divided into early and late manifestations. The superficial lesions of early syphilis are infectious. The tertiary phase of late chronic infection is destructive, particularly affecting the heart, the brain, and bone. The infection responds to treatment with penicillin and other antibiotics. In the UK, pregnant women are routinely screened serologically for syphilis.

In the UK, syphilis was becoming rare and there was talk of dropping its screening in early pregnancy, that is until the Bristol outbreak some five years ago. Other outbreaks have since occurred across the UK and Europe.

Domestic Violence

Domestic violence (DV) affects people of every class, age, race, disability and sexuality. DV has strong links with sexual health. The Council of Europe found that 1 in 4 women experience DV over their lifetime and between 6-10% of women suffer DV in a given year. Repeat victimisation is common. Of 635,000 incidents in England and Wales in 2000/01, 81% of victims were women and 19% were men.

Research indicates that abused women are more likely to suffer from depression, anxiety, eating problems and sexual dysfunction. DV is a factor in at least 1 in 4 suicide attempts by women. Work is being carried out into the plausibility of screening for DV in general practice. This may be premature but practitioners need to be aware of the possibility of violence and offer support, general advice and information about agencies that can help **(24)**.

As many as 30% of cases of DV start or escalate during pregnancy. In addition to the obvious distress caused, DV causes miscarriage, premature delivery, low birth weight, abruption, stillbirth and maternal death.

The effect of DV on children is profound. The impact on the child's health include for example, triggering or worsening bedwetting, asthma, eczema or psoriasis. Children sustain injuries when caught up in the violence.

In Walsall over 4,000 incidents of DV are reported to the police each year. This is just the tip of the iceberg since thousands of incidents go unreported. The Domestic Violence Forum in Walsall co-ordinates the many services across the Borough designed to meet the needs of families suffering from DV. These include the Women's Refuge, the Stepping Stones support group, SAYA (a multilingual help line) and the Crisis Intervention Service that works with the police to give support to a victim when they have removed the perpetrator. Other projects include Stopping Aggression in the Family Environment, a service for men who want to stop being abusive towards their partners. Walsall also has a midwives clinic drop-in centre based in Blakenall Community Association, a schools programme, and training programmes run two days a week for professionals across the borough that offers information on how to spot signs and help victims.

JACKIE'S STORY

Jackie has been living with Ian for 2 years. She finds him very caring. He doesn't like her to go out without him in case anything happens. He's bought her a mobile phone so he can always get in touch, even when she is at work. She adores him. They are both very excited when they learn they will have their first baby in July.

Ian suddenly changes. He is short tempered and he has even smashed things about their house. One day Jackie misses the bus so is late coming home from work. When she arrives home Ian is furious and thumps her. Jackie is astounded; he has never hit her before. Ian tells her it will never happen again, he blames stress at work and impending fatherhood. He promises he will never hurt her again. That was the first time.

Their baby Ben is now 18 months old. Jackie is tired of all the beating and emotional abuse that she suffers but feels she has no choice but to put up with it. Who would believe her if she told anyone? Ian is such a charming and kind person; he is employed as manager in a caring profession and does a lot of voluntary work in Walsall.

The development of No More Excuses in 1999 (Walsall's Strategy to Reduce Domestic Violence) aimed to ensure good practice and joined up working across the agencies in the borough. Projects and services in Walsall have been designed to help meet the aims and objectives of the strategy.

Walsall's sexual health strategy

Actions relating to women
A. BETTER PREVENTION

The following are key areas of where we are and where we need to be in Walsall:

1. Waiting times for colposcopy are unacceptably long and for informing women of their biopsy results. This needs to be a priority area of the cervical screening programme in Walsall.

2. Early access for termination of pregnancy needs to be enhanced, with a particular focus on the new service for medical termination.

3. Uptake of antenatal screening for HIV needs to be maintained above 90% and ideally moved towards the 100% routine uptake.

4. The emergence of Crisis Point has highlighted a gap in Walsall's service provision, and there is a need to fund and support this agency to address the needs of vulnerable women, at the same time complementing the work of SAFE.

5. The joint working being undertaken between SAFE and Addaction to reduce risk taking behaviour of CSWs with regard to safer sex and drug use needs to be strengthened further.

6. Although female genital mutilation has not been identified as a problem, all professionals need to be aware of it.

7. Further work is required with the Probation Service on providing support for prisoners released back into Walsall, including linkage where necessary with the Youth Offending Team and Crisis Point.

Rape can happen to anyone, anywhere…

Sarah is out for a Friday night to meet up with old friends in Walsall town centre. They end up in a club. Sarah becomes isolated at around 1 in the morning and can't be bothered to wait in the queue for a taxi. She starts to walk home. On her way a man she knows and recognizes from the club, stops her in his car and offers her a lift. Sarah accepts. She has probably drunk one too many vodkas because she didn't realize that she'd been taken off the beaten track.

Sarah becomes frightened when this man starts to touch her; she starts to cry and begs, "please don't". The man gets angry and hits her. Sarah is so frightened that she cannot scream, she cannot move. The man rapes her. He threatens her not to tell anyone.

Sarah walks away, crying, ashamed, frightened and confused.

Do you know who Sarah is?
Sarah is your sister. She is your friend. She is someone you know.

The facts:

- It is estimated that 500 women aged 16-59 are raped each year in Walsall: nearly 10 women a week
- 31% of victims never told anyone about the last incident of rape, 35% told someone later
- Only 1 in 20 rapes are reported to the police

Help and advice:

- CRISIS POINT is a confidential counselling help service
  Phone Caz on 07966578498. We believe you.
- National Help lines: 0808 800 0123/0122 (Rape)
- You can also speak to your GP or the police

MEN

chapter 3

Two important STIs not so far explored in this report are HIV and syphilis, both strongly associated with the gay and bisexual community, conventionally described as men who have sex with men (MSM). Accordingly, a significant portion of this chapter is concerned with the Men's Health project and with people living with HIV. The project also aims to increase awareness of two cancers that are specific to all men.

Cancer

Unfortunatley the scope for prevention is limited. Although increased fruit and vegetable consumption is likely to reduce risk of urological cancers, there is no reliable evidence that population screening reduces their mortality. For prostate cancer, systematic reviews have concluded that screening using PSA (protein specific antigen) testing currently cannot be justified.

Prostate cancer

Mortality rates for prostate cancer have been increasing nationwide, although increase in incidence may also reflect the more recent detection of early, asymptomatic disease. The main reason is use of PSA testing, which became commonplace during the last decade. Neither the causes of prostate cancer nor the reasons for the increase in mortality rate over the past thirty years are known, although some risk factors have been identified.

Hormones are important, especially high levels of testosterone. Genetic factors feature in about 9% of cases, particularly when the disease develops at a young age. There is wide variation between ethnic groups, probably due to differences in diet, eg increased risk associated with high animal fat intake.

Prostate cancer usually progresses slowly with prognosis depending heavily on grade of the tumour. Treatments range from active monitoring and conservative treatment of symptoms (watchful waiting) to radical surgery (prostatectomy).

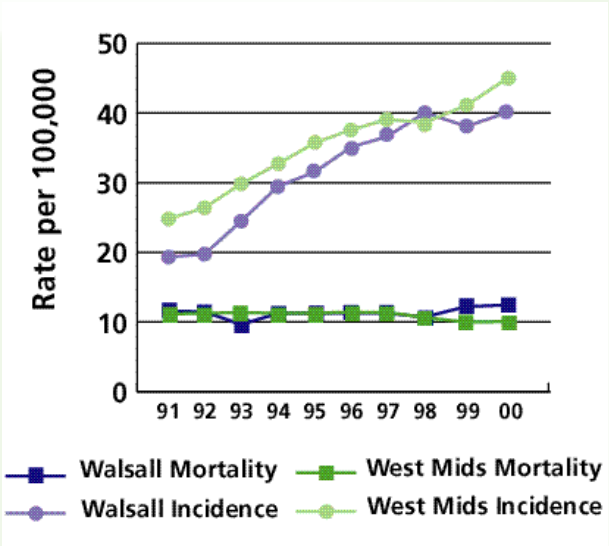
In Walsall over the last decade, the number of cases of prostate cancer almost doubled from 53 to just over 100 cases per year. **Table 3.1** shows how deaths from male genital cancer have increased over a recent 3-year period. The net increase of 10 deaths is attributable to prostate cancer, which accounts for 95% of cancer mortality in male genital organs. **Figure 3.1** shows that Walsall and regional death rates from prostate cancer were very similar in the 10 years up to 1997 but by 2000 the Walsall rate was 36% above the regional rate (13.15 vs 9.66), although absolute differences are small.

Table 3.1 Recent trends in Walsall male genital cancers

Male Cancers	1995-97 Deaths	1995-97 Rate	1998-00 Deaths	1998-00 Rate	Change in Deaths
Prostate	48	10.75	58	13.15	+10
Testis	nil	nil	2	0.52	+2
Penis	2	0.48	1	0.25	-1
Other	1	0.27	nil	nil	-1
Total	**51**	**11.45**	**61**	**13.92**	**+10**

Source: West Midlands Cancer Intelligence Unit, Cancer Information Service

Figure 3.1 Incidence and mortality of prostate cancer in the under 75s (Walsall and regional rates, 3 year rolling averages up to dates listed)



Source: West Midlands Cancer Intelligence Unit, Cancer Information Service

Incidence of prostate cancer in the under 75s has increased substantially over the last decade, both in Walsall and the region.

TESTES SELF EXAMINATION

Young men are notoriously disinterested in health. Few examine themselves even after specific teaching and there is no evidence that educational interventions intended to encourage them to do so are effective.

Testicular cancer

There has been a continuous rise in the incidence of testicular cancer over the past few decades. A large case-control study in England and Wales had elucidated some aspects of the aetiology of this disease; revealing significant associations with congenital abnormalities, particularly undescended testes, early age at puberty, and sedentary lifestyle. The majority

of cases are identified at an early stage, however, and this form of cancer can usually be cured even when it has spread beyond the testis.

Belief is widespread among health professionals that young men should be educated to examine their testes for lumps in order that any cancer might be treated as quickly as possible. But young men are notoriously disinterested in health. Few examine themselves even after specific teaching and there is no evidence that educational interventions intended to encourage them to do so are effective.

There are two main types of testicular tumour, seminoma and non-seminoma (based on cell type). Surgery is used to treat both types and may be sufficient to control the disease. Patients with seminoma are treated with post-operative radiotherapy, whilst chemotherapy is more appropriate for patients with non-seminomas. Success rates are high since fewer than 10% of patients die from testicular cancer. Over the last 10 years in Walsall the number of cases of testicular cancer have varied between 5 and 9 cases per year, and over the 3 years 1998-2000 there were 2 deaths.

HIV and AIDS

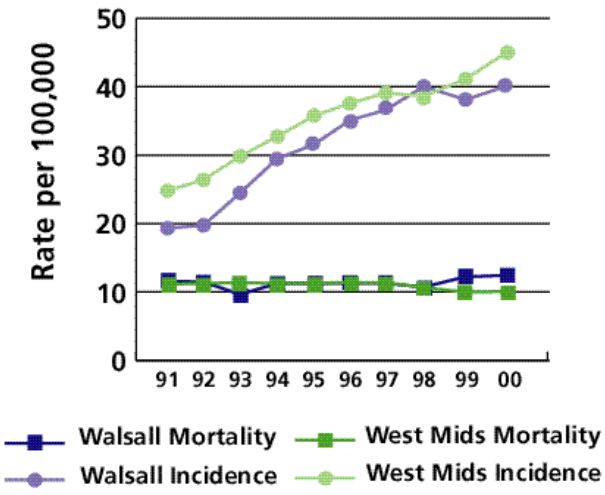
It is estimated that in the UK a third of those living with HIV infection are undiagnosed **(9)** and that up to 75% of patients are diagnosed late **(25)**. There are three main reasons for this:

1. Patients do not present until they become ill with HIV-related symptoms, because of -
   - lack of education about benefits of early diagnosis
   - lack of awareness of being put at risk
   - fear
2. Patients present with symptoms but HIV is not considered, especially if they do not admit to being at high risk
3. Patients arrive in this country from overseas already immunosuppressed.

These points illustrate the importance in the sexual health strategy of offering the HIV test to groups at risk. These groups will be apparent when considering the HIV data relating to Walsall.

Figure 3.2 shows the dramatic rise in incidence of HIV cases presenting to the Walsall GUM clinic and increasingly overwhelming the service. There is also a recent trend of female cases exceeding male. Up to the end of 2001, around 50,000 people infected with HIV had been reported in the UK, of whom nearly 15,000 had died of AIDS-related illness **(26)**. While men who have sex with men (MSM) had

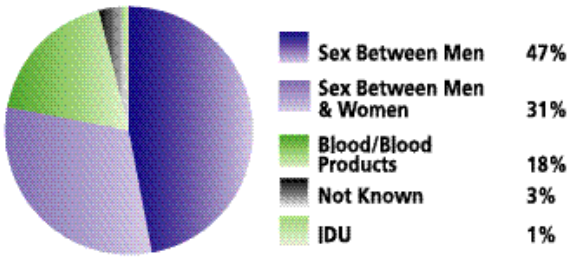
Figure 3.2 Number of new HIV cases, Walsall residents, 1996-2002



Source: West Midlands Regional HIV Surveillance Project

long remained the group at greatest risk of acquiring HIV in the UK, this route of transmission was overtaken by heterosexually acquired HIV in 2001. Most of the latter were probably acquired overseas, the great majority (estimated 71%) in sub-Saharan Africa. **Figure 3.3** shows that of the 77 Walsall residents so far diagnosed with HIV up to the end of 2001, 47% were from the MSM group. Those infected by blood transfusion and products are no longer seen because of effective screening, while infection among injecting drug users is rare following the advent of effective needle and syringe exchange.

Figure 3.3 Distribution of 77 Walsall residents diagnosed with HIV up to the end of 2001 according to source of transmission

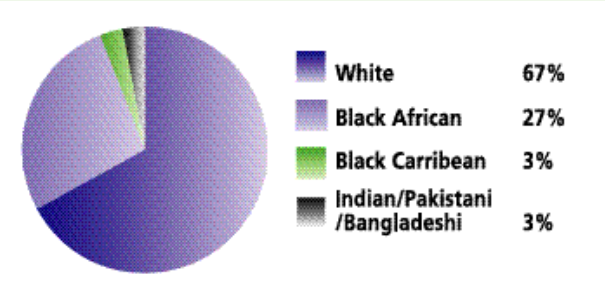


Source: West Midlands Regional HIV Surveillance Project

Just a year later to the end of 2002, there were 102 residents diagnosed with HIV, including one (the first in Walsall) mother to infant transmission: 42 were infected by the MSM route, rapidly caught up by 39 infected heterosexually (20 women, 19 men, with a total 27 citing partners living overseas). **Figure 3.4** shows ethnicity and increasing prominence of

African people. Most residents living with HIV AIDS are aged 25-39 years, followed by the 40-54 year age group.

Figure 3.4 Ethnicity of diagnosed HIV infected people resident in Walsall, up to the end of 2001



Source: Survey of prevalent HIV infections diagnosed (SOPHID)

Returning to the 102 Walsall residents so far diagnosed with HIV up to the end of 2002, **Table 3.2** provides a distribution according to death and health status while alive. The number living was then 86 and the proportion living will increase with time given now available effective therapy. At that time, there were 44 Walsall patients on triple therapy, two on dual therapy, and 15 on other forms of treatment.

Table 3.2 Status of 102 Walsall HIV residents up to the end of 2002

Clinical Stage to Date	West Midlands	Walsall
Asymptomatic	889	55
Symptoms pre-AIDS	268	7
Symptoms - AIDS	507	22
Death - AIDS	394	13
Pre-AIDS death	77	4
Unknown	252	1

Source: West Midlands Regional HIV Surveillance Project

While **Table 3.2** provided a regional perspective to Walsall numbers, it is useful to present the total of 102 cases diagnosed till the end of 2002 in the context of the Strategic Health Authority area. Birmingham has had the most number of HIV cases to date, as follows (number per 100,000 population):

1. Birmingham 92.6
2. Wolverhampton 73.2
3. Walsall 40.3
4. Dudley 24.9
5. Sandwell 21.3
6. Solihull 10.9

The reasons for the above differences are complex.

Sexual behaviour is a major factor determining incidence of HIV. The 2nd National Survey of Sexual Attitudes and Lifestyles **(6, 7)** shows that there have been notable changes in sexual behaviour since the first survey in 1990.

These include:

- a greater number of lifetime partners
- lower age at first intercourse
- a greater proportion of the sample with concurrent partnerships
- a greater proportion with two or more partners in the past year who did not use condoms consistently

Data from Sigma Research **(27)** show that MSM in 2000 reported increases in unprotected anal intercourse with both regular and casual partners compared with 1995.

Walsall Men's Health Project

This project has been funded for a number of years by HIV prevention monies, initially engaging with the Walsall MSM community at the Greenhouse Sauna and the Golden Lion Public House. This work continues but also integrates men's health issues through other agencies. The initiative is led by a dedicated project officer supported by sessional workers, with specialist supervision provided by a regional co-ordinator working to national guidelines.

The Lion Night Club and Bar attracts a mixed gay, bisexual and straight customer base, and promotes a community attitude to involvement in events such as World AIDS Day, community policing, and support for HIV and STI prevention. Regular work at this venue involves distribution of information, condoms and lubricant on a weekly basis, through the regular presence of a sessional worker. This venue has hosted a screening process in response to a recent Walsall cluster of syphilis cases, supported by GUM outreach. Further sessions are planned, including offer of hepatitis A and B vaccines, and HIV testing. The cluster suggested the Walsall sauna as a potential area of transmission.

HIV IMPACT ON SEX

Following the emergence of HIV and the extensive media coverage of AIDS, diagnoses of syphilis and gonorrhoea in the UK declined sharply following adoption of safer sex practices. There was a subsequent decrease in HIV transmission among MSM. However, these changes have not been sustained and STIs have increased again since the early 1990s. Added to this, HIV is no longer perceived as a death sentence. Population behaviour responds to the HIV epidemic. Now there is a dangerous complacency around safer sex and there is increasing promiscuity.

HIV PREVENTION
TARGETING MSM POPULATIONS

The UK Health Development Agency has recommended the following policy and practice in relation to interventions:

- ❑ Place interventions within the broader context of men's lives, addressing the range of factors which influence risk at both the personal level (eg knowledge, skills) and the structural level (eg discrimination towards MSM).
- ❑ Target interventions to specific sub-populations of MSM (eg specific ethnic groups)
- ❑ Undertake multi-component small group work, focusing on risk reduction, sexual negotiation and communication skills training and rehearsal.

The Greenhouse Health Club is a men-only sauna situated close to the M6, easily accessible for men from around the country. The venue sees around 600 at the weekends, comprising mainly gay men. During the week it sees around 150 each day, when it attracts larger numbers of bisexual men who are in heterosexual relationships. Screening exercises are planned for this sauna venue on a regular monthly basis, also with a future view to a Well Men Clinic covering issues such as blood pressure, cholesterol, body fat measurement, HIV and syphilis screening, testicular examination, and erectile dysfunction.

World AIDS Day

Each year on the 1st December the project takes an active role in HIV awareness activities.

Campaigns

The Men's Health Project participates in national awareness campaigns provided through CHAPS (Community HIV and AIDS Prevention Strategy) on various issues throughout the year, and produces in-house posters to localise such national campaigns.

Research

Sigma Research is a social research group that specialises in the behavioural and policy aspects of HIV, AIDS and sexual health. It has an international reputation as one of the most important and innovative sources of new social scientific information in these areas. The Men's Health Project takes part in an annual men's sex survey, following which reports are used to inform work for the year ahead.

Training

Training around homophobia, assertiveness and HIV awareness are provided to user groups. There are also discussions with the police and probation service regarding the provision of training.

Drop-in and Social group

This targets men who do not normally access the commercial scene. The group is friendly, tolerant and welcoming to new members. It is member led and primarily used as a social group, where informal discussions occur of the week's news and articles that appear in the free gay press. Membership is currently around 50.

PuMA

This is an awareness and self support group for men who are HIV positive. Membership is currently at 13. The group regularly invites guest speakers on issues such as benefits, treatments and healthy eating.

PP group

This is another support group for people living with HIV; open to haemophiliacs, asylum seekers, whether gay, bisexual or heterosexual and their partners and carers. It gives the opportunity for people to talk about HIV medication and services. It is facilitated by the HIV Co-ordinator (Social Services) and GUM Health Adviser, and housed by the project.

Police Liaison

The main aim is to raise the profile of sensitive policing of the gay community. The Vulnerable Person's Officer along with the project hold surgeries once a month at The Golden Lion, covering such issues as homophobic crime and domestic violence.

Electric Palace

Since there are no young gay, lesbian, bisexual, and transgender support services in Walsall, the project has commissioned a needs assessment of this client group by Walsall's Electric Palace youth agency.

A KILLER CRAZE

An ever-growing number of healthy gay men are actively trying to contract HIV. Attempting to join the HIV brotherhood is the latest craze to sweep through America's gay and lesbian communities. The craze has been dubbed bug-chasing and it is claimed that up to 25% of all new HIV cases in the USA result from this. It is also claimed that chasers get an emotional high from knowing that they are indulging in reckless sex and are probably about to become HIV positive. Could this be another export from America? Colin Powell has seen fit to describe HIV and AIDS as a greater threat to world safety than terrorism.

Cottaging, Cruising, and the Internet

This work targets men who access public sex environments, respectively toilets and parks. Around 17 men are currently targeted, although there has been a significant reduction in the numbers, making outreach sessions less productive. This is due to an upsurge in the use of web-based chat rooms. In response, a profile for the project has been set up on the most popular internet-based gay personals site (gaydar.co.uk), which attracts people seeking health advice and information with total anonymity. The project is currently developing a datewise website which gives advice and information on safer internet dating.

HIV health and welfare provision

This is led by the HIV Co-ordinator (Social Services) who has identified the following key issues in Walsall **(28):**

- asylum seekers, especially from areas endemic for HIV, may increase future demand for services
- drug resistant HIV transmission is increasing, which will lead to the need for earlier health and social support
- people with HIV are living longer and often have specific mental health needs, requiring more input
- the Supporting People Strategy needs to more effectively address issues of housing for people with HIV
- all services need to take steps to reduce the stigma of HIV and improve accessibility
- user groups need to be better funded

The Local Authority will need to actively consider planning future service needs around these issues.

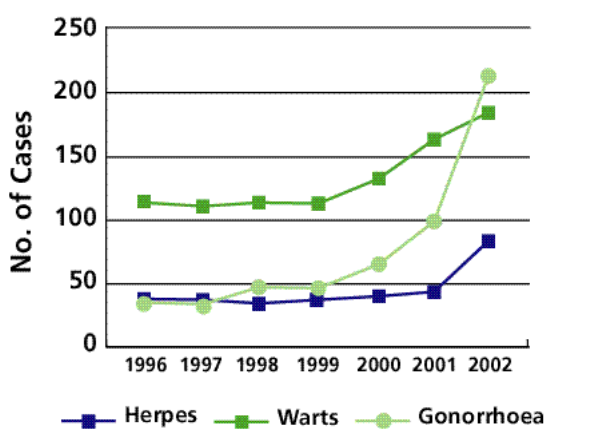
Terrence Higgins Trust project

This is a jointly funded venture between Walsall and Wolverhampton to provide HIV prevention for local African populations (around 500 Walsall population). A primary target has been health sector professionals and students. Access to this group is enabled by the trust providing dedicated African workers who are trained in health promotion initiatives. The project was initiated following the media coverage of the Wolverhampton nurses infected with HIV a few years ago and is now sustained by the rise in prominence of heterosexual transmission with links overseas.

Syphilis and other STIs

As with HIV, **hepatitis B virus** (HBV) is a blood borne virus also spread by the sexual route. The success of the GUM outreach sessions described above in the community setting, whereby the HBV vaccine is given at the time of MSM screening, is encouraging. The national strategy has set targets for uptake of this vaccine by MSM attending GUM clinics. This Walsall HBV campaign will work in parallel with that targeting injecting drug users. The vaccine against hepatitis A virus will also be offered since outbreaks have occurred in both communities elsewhere in the country. **Figure 3.5** shows the increasing trends of leading STIs among all men in Walsall, including a recent rise in gonorrhoea cases.

Figure 3.5 STI trends in Walsall men, 1996-2002



Source: Source: West Midlands Sexually Transmitted Infections Surveillance Project

Until recently, **syphilis** cases in Walsall numbered one or two per year. In England, cases increased by 431% between 1998 and 2001 with many outbreaks among MSM, notably in Manchester and London **(29)**. This pattern may be spreading to the Midlands since 8 Walsall cases were detected in 4 months from the end of 2002 and are now continuing. One was a man with asymptomatic syphilis, detected among 60 MSM by GUM outreach screening. This indicates other undiagnosed infections among the gay community. This case and 4 others detected in the GUM clinic (one with an oral lesion) had all attended the Walsall sauna and all admitted casual unprotected sex, although not with each other. One case was also HIV positive.

This cluster of cases is probably related to the Manchester outbreak as Walsall is close to the M6 and the sauna is attended by men from the north of England. Accounts of MSM with syphilis support evidence of increasing risky sexual behaviour. In all outbreak sites, co-infections with HIV have also been reported. Since effective antiretroviral therapies have increased prevalence of HIV, risky behaviour allied to the recent growth of saunas and internet chat rooms have increased opportunities to acquire new sexual partners and so facilitate transmission.

The work of the Men's Health Project and GUM outreach team through screening and promoting safe sex will clearly be important to control HIV and syphilis among MSM in Walsall.

Walsall's sexual health strategy

Targets relating to HIV and HBV are as follows:

By the end of 2004, all GUM attendees should be offered the HIV test, with:
- 40% uptake by end of 2004
- 60% uptake by end of 2007

By the end of 2003, all gay or bisexual men attending GUM should be offered the HBV vaccine with:
- uptake of 1st dose, 80% by end of 2004
- uptake of 1st dose, 90% by end of 2006

Actions relating to men
A. BETTER PREVENTION

The following are key areas of where we are and where we need to be in Walsall:

1. Strengthen the Terence Higgins Trust project addressing HIV in Africans.
2. Promote increased use of the national AIDS help-line, the national African AIDS help-line, and the Walsall help-line based at GUM.
3. Establish development of a regional gay men's website.
4. More work is needed in schools to address homophobia and support young people with issues around sexuality.
5. Establish contacts with asylum seekers to address issues around HIV.
6. Strengthen the health and welfare provision of people living with HIV, especially in terms of their mental health and housing needs.
7. Sustain the work of the Men's Health Project, especially in health promotion and screening at MSM venues.
8. Ensure increased GUM resources to sustain outreach activity in association with the Men's Health Project.

Other actions appear in:
B. BETTER SERVICES (Chapter 4).

How safe is your sex life?

Paul is a married man with three young children, the youngest being three months old. Over the past few years, on his way home from work, he has been calling into a local sauna in order to meet other men for sex. Although he is normally obsessive about safer sex and usually uses condoms, he recently developed a rash and elected to be screened at a 'Well Man Clinic' session provided at the sauna by the Men's Health Project and GUM services. A blood test revealed that he had secondary syphilis infection and he was notified of this by text and advised to attend the GUM clinic for treatment.

He now has the unenviable task of telling his wife of his condition and her need to be screened. He is also now quietly worried about HIV. He his ashamed, frightened and has an overwhelming sense of guilt and regret.

Do you know who Paul is?
Paul is your brother. Paul is your friend. Paul is the guy next door.

The facts

The number of syphilis cases in England and Wales has risen dramatically over recent years.

Syphilis (primary and secondary)	1996	1997	1998	1999	2000	2001	2002	% 01-02	change 96-02
Total Males	84	98	87	156	247	616	1030	67%	1126%
- of which homosexually acquired	20	18	23	52	119	350	589	68%	2845%
Total Females	32	49	44	55	75	99	137	38%	328%
Total	**116**	**147**	**131**	**211**	**322**	**715**	**1167**	**63%**	**906%**

Help and advice

- Walsall Men's Health Project 01922 613141 wmhp@btclick.com
- Walsall GUM clinic 01922 633341
- You can also speak to your GP (Family Doctor)
- RELATE (relationships counselling) 01922 626004

SERVICES

The principal services providing for sexual health and HIV are Family Planning (FP) and Genitourinary Medicine (GUM).

A SHAMBLES

The House of Commons Health Select Committee has published its inquiry on sexual health, highlighting a major public health problem and increasing crises. The committee's chairman said they had been frankly shocked and appalled by some of the evidence.... the whole sexual health service seems to be a shambles.

Family Planning

The provision of FP services is a key component of Walsall's sexual health strategy. The main specialist (Tier 3) provider is the Hatherton Centre, providing advice on contraception and sexual health, including advice for teenagers and emergency contraception.

Hatherton Centre

While the centre provides for people of all ages, it is increasingly providing accessible and user-friendly contraceptive services for young people, since reducing the number of teenage pregnancies is a key government target (**30**). Walsall already offers a free condom scheme from selected GP surgeries across the borough to help meet this target. At the centre, there are 2 sessions weekly specifically for targeting young people under the age of 19 years. Another session operates from the centre by the GUM department as a one stop shop facility, specifically for treatment and information on STI's. All 3 sessions are operated on a drop in basis. The centre is now aiming to launch a satellite one stop shop in Willenhall, aimed at young people. More recently, the centre is also prioritising early referral for termination of pregnancy. The Hatherton Centre provides:

1. generic family planning
2. sexual health information
3. pregnancy counselling
4. pregnancy testing
5. IUD fitting
6. vasectomy counselling
7. cervical cytology screening
8. menopause counselling
9. teenage specific programmes
10. education programmes

There is also counselling for psychosexual problems and promotion of fertility awareness.

All clients are treated within the boundaries of confidentiality and data protection. The centre operates nurse-led and doctor sessions. Nurses can now supply, within group protocols, emergency contraception and initial supply of oral contraceptives and Depo-Provera contraceptive injection. The centre has recently set up a domiciliary service aimed specifically at hard to reach groups, with the assistance of the midwives. A FP nurse contributes to an active education roll out programme, visiting almost all secondary schools in the borough to deliver sex education jointly with a health adviser from the GUM clinic. There is a roll out programme of 17 pharmacists providing emergency contraception to Walsall residents. In addition, the majority of GPs in the borough offer core contraceptive services.

VISION FOR BETTER SERVICES AND BETTER SEXUAL HEALTH

In 10 years time, Walsall people will have the right to expect:

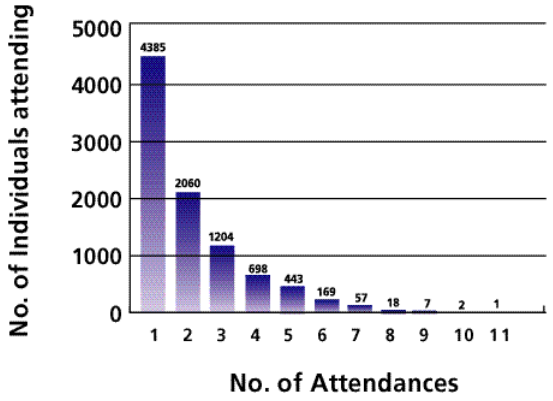
- ❑ greater choice about sexual health services
- ❑ greater awareness of sexual health through open debate
- ❑ properly resourced and managed sexual health services accessible to all
- ❑ integrated and multiagency sexual health services that are non-discriminatory
- ❑ acceptance of the whole diversity of human sexual experience
- ❑ reduced stigma around HIV, STIs and abortion
- ❑ victims having a voice to reduce sexual abuse, sexual violence and rape
- ❑ a reduction in health inequalities and social exclusion

Table 4.1 Distribution of 9,044 people attending the Walsall FP Centre by gender and age group, 2002 (total 18,775 attendances)

Age	Females	Males
Under 16	334	47
16 to 17	914	243
18 to 19	920	158
20 to 24	1673	172
25 to 39	2886	416
40 to 54	959	199
55 & over	93	30

Source: Walsall PCT, Information Services

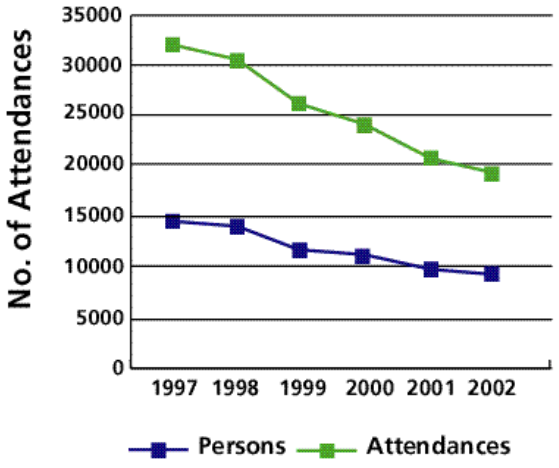
Figure 4.1 Number of attendances by 9,044 people at the Walsall Family Planning Centre, 2002



Source: Walsall PCT, Information Services

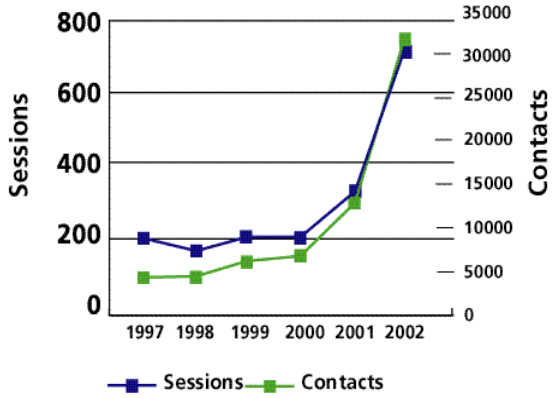
In 2002 there were 18,775 attendances at the Hatherton Centre by 9,044 individuals. **Table 4.1** shows that the majority are over 19 years of age, with an expected excess of females. Many of the service users reattend, as shown in **Figure 4.1**. In addition to this activity data for 2002, there were 725 sessions for health education sessions following a total 27,859 contacts, mostly by telephone (19,522). **Figure 4.2** shows a decline in numbers of people attending the Hatherton Centre, 1997-2002. A greater decline in contact numbers reflects a reduction in number of reattendances, associated with increasing growth of other agencies noted below, including GPs. The condom scheme and increased availability of condoms for purchase has also had an impact At the same time, health education sessions at the centre have escalated as shown in **Figure 4.3**.

Figure 4.2 Number of people attending (and total attendances) the Walsall FP centre, 1997-2002



Source: Walsall PCT, Information Services

Figure 4.3 Individual health education sessions and contacts (inc. by telephone) at the Walsall FP centre, 1997-2002



Source: Walsall PCT, Information Services

Primary Care

As noted, the participation of Walsall GPs is key and the free condom distribution scheme is complemented by professionals trained to demonstrate their use. In 2000, a survey of 17 practices in the West Walsall PCG area aimed to ascertain the sexual health services provided **(31)**. **Table 4.2** indicates the range of Tier 2 level services provided. More could be offered but constraints mentioned included the need for more time, training, resources, and trained nurse support. The report made a number of recommendations consistent with those relating to services at the end of this chapter

Table 4.2 Availability of a range of sexual health services at 17 general practices, Walsall West Primary Care Group, 2001.

	Offer now	Would offer	Never offer	No response
Antenatal services	17	0	0	0
Pregnancy testing	1	9	6	1
Contraceptive pill	17	0	0	0
Condoms – male	11	4	2	0
Condoms – female	3	8	5	1
IUDs (inc. fitting)	9	4	4	0
Diaphragm (inc. fitting)	4	5	6	2
Rhythm method advice	10	1	6	0
Implants (inc. fitting)	5	4	8	0
Injections (Depo-Provera)	14	1	2	0
Emergency contraception	17	0	0	0
Referral for termination	17	0	0	0
Counselling on sex related issues	17	0	0	0
Prevention of unwanted pregnancy	16	1	0	0
Prevention of STIs, including HIV	14	2	0	0

Source: Walsall West PCG Sexual Health Survey

GUM clinic

This department within the Manor Hospital offers Tier 3 level contraceptive services, testing, advice and counselling regarding pregnancy and termination, in addition to services for STIs and HIV. Rape crisis counselling and emergency contraception are also provided. The service is important since it is widely perceived as confidential and associated with self-referral (around 90% of contacts).

Other FP providers

Many other agencies provide Tier 1 or 2 level FP services, especially to provide contraception and facilitate pregnancy testing, and a selection appears below:

1. Pharmacies
Currently 17 are successfully implementing a scheme for emergency contraception. There are plans to further expand this scheme.

2. WALCAT
Walsall College of Arts and Technology has established a sexual health service using a peer education approach with students being trained to run the service. A trained midwife also offers a one stop sexual health clinic.

3. Walsall Pregnancy Help
Based at the Deaf Centre on Lichfield Street, this service offers counselling and advice for all ages and free pregnancy testing.

4. Electric Palace
Based in Bloxwich, this Community Association project offers information to young people on sexual health, and outreach and FP sessions in partnership with Walsall Pregnancy Help after school. Trained staff distribute condoms.

5. Walkways
This town centre based detached youth work project also offers advice and counselling on sexual health issues, including condom demonstration.

6. School Nurse Drop-in Centre
Some schools offer drop-ins run by school nurses.

Brook Clinic, Birmingham

Provides specialist sexual health services dedicated to young people. Sandwell also has a Brook. While many young people prefer the anonymity of seeking help outside, there is need to consider one or two Brook satellites in Walsall to support the work of the Hatherton Centre.

Genitourinary medicine

Previous chapters have documented the dramatic increase in numbers of people presenting to the Manor Hospital GUM Department with STIs and HIV. This is further borne out by microbiology data, eg 90 Chlamydia positive specimens in 1998 rose to 378 in 2002, and 75 gonorrhoea positive specimens in 1998 rose to 252 in 2002. The rise in overall activity levels shown in **Table 4.3** illustrates how the service is being overwhelmed. This is reflected in a 10 day waiting time for GUM appointments, against a recommended 48 hours.

Table 4.3 Activity levels of patients attending Walsall GUM clinic, 1999-2002

	1999	2000	2001	2002
New	3194	3732	3929	4712
Follow up	6250	7214	7752	8629

Source: Walsall GUM clinic

The department currently staffs one GUM consultant, supported by a staff grade practitioner, and so there is a pressing need for recruitment of at least an additional (second) GUM consultant based on the recommended 2.4 per 250,000 population (Walsall's population level). Expanding the present nursing, counselling, and support staff is also required. The existing physical facilities are woefully inadequate, especially given the provision of additional innovations:

- contraceptive services (inc. emergency contraception)
- clinic for erectile dysfunction
- management of genital dermatoses
- management of abnormal cervical smears
- evening walk-in session for teenagers
- outreach referral facility for commercial sex workers
- screening hepatitis B and C among injecting drug users
- outreach screening for syphilis and HIV among MSM

Added to which, the National Strategy will place further pressure on GUM services by:

- setting targets to offer HIV counselling and screening for all clinic attendees
- various target setting in offering the hepatitis B vaccine
- expecting the development of services to outreach to the community through tier 1 and 2 provision within primary care
- integrating with family planning services and participating in a more strategic community approach.

HAART

Highly active antiretroviral therapy (HAART) has had a dramatic impact on the morbidity and mortality associated with HIV infection. Death rates fell by 70% between 1995 and 1997 following its introduction. HAART is used to describe a regimen of three or more antiretroviral drugs. The CD4 count is an important measure of immune status in HIV, a useful guide to therapy, and of prognostic significance.
HIV therapy is one of several activities that requires a main GUM provider to remain based in the acute hospital setting.

The plight of the Walsall GUM service prompted a recent evaluation **(32)**. A literature search identified 3 guidelines for GUM service standards: effective commissioning of sexual health and HIV services **(33)**; service standards in GUM **(34)**; and standards for sexual health services for young people under 25 year **(35)**. The service in Walsall was evaluated using these standards **(Table 4.4)**. The main findings were:

1 an expected under-staffing in terms of consultants and health advisers, which hampers provision of specialist services and outreach work;
2. inadequate storage at the clinic, meaning that regulations regarding the handling of patient data and privacy are being contravened; and
3. inadequate clinic facilities and layout, making it difficult to ensure patient privacy (users have complained about perceived threats to their privacy at the GUM clinic).

Despite these drawbacks, access targets were met and Walsall had significantly better waiting times compared with neighbouring services. Most standards relating to the provision of core services were met. HIV service standards were met and there were high levels of patient satisfaction. However, there was limited access to other care, including social care, local palliative care services and mental health services. This is particularly important given the increasing number of HIV positive asylum seekers with complex health needs. The core service met sexual health services standards for people under 25 years. The limited links with other youth and social care agencies is a weakness and there was limited training in child protection issues. There was excellent health promotion activity and increasing levels of outreach work with the gay community, drugs service and commercial sex workers.

Local stakeholders including the FP service, Addaction, the Men's Health Project, and SAFE were asked for their views about the GUM service. Key themes were summarised as follows:

Strengths
- Good links with drugs service
- Pro-active community outreach work with gay community
- Good links with local schools via health advisor
- Very good HIV service
- Access times good
- Clinical staff very friendly

Weaknesses
- Poor physical environment at the clinic
- Lack of joint working between FP service and GUM service
- Ensuring privacy for certain groups (gay men, commercial sex workers) hampered by having designated clinics/set times for HIV testing.
- Location of reception and waiting room in close proximity – perceived threat to user privacy
- Concerns about treatment by some reception staff – asking for more details than strictly necessary ?

The conclusion was that the GUM clinic provided a remarkably good service despite severe handicaps of staff shortage, inadequate physical facilities, and a certain lack of privacy.

Tackling rising rates of STIs and associated health inequalities requires the development of accessible and appropriate sexual health services. In addition, these services have to be developed in the context of wider NHS reform. There is need to modernise services, centre them around patients, and develop provision in primary care, utilising new ways of working **(36)**.

THREE KEY MOVES

GUM and FP services would be substantially improved by:

- ❑ Appointing a second GUM consultant and more support staff
- ❑ Appointing a consultant Community Gynaecologist
- ❑ Introducing a Brook Clinic input to support the work of the Hatherton Centre.

Community Gynaecologist

There is clearly a need to strengthen Walsall's GUM department and to assist it in developing Tier 2 level services in primary care across the borough. Also to develop a more integrated service with FP. Initiatives are already in place, but these need to be driven by a senior clinical appointment, tasked with an additional role of boosting the commissioning process.

Table 4.4 Evaluation of Walsall GUM services

SELECTED STANDARDS	SERVICE IN WALSALL –STANDARD MET?
STAFFING AND ACCESS	
Consultant led service 1 consultant per 100,000 population	No - 1 consultant. 1 Associate Specialist (due to retire soon) for population of 250,000. Understaffed
Appropriately qualified health advisers and nurses	Yes – but understaffed. Currently 1.5 WTE. 1 HA works in GUM but should be whole-time teenage community schools liaison
All medical staff – Diploma in FP	Yes. Doctors accredited in FP; 2 nursing staff trained in FP
Open access. Max 2hr waiting for walk-in	Yes. 3 walk-in clinics 3 per week. All emergencies seen within 24 hrs
3 days clinical sessions per week/ one session out of normal hours	Yes Teenage clinic offered in evenings
Access to female doctor where possible	Yes
SERVICE	
Screening and therapy for STIs/common dermatoses. Full sexual health screen	Yes
HIV testing offered to all new attendees	Yes
Post-exposure prophylaxis: HIV & HBV	Yes
Hepatitis B screening and vaccine for all: gay men, commercial sex workers, injecting drug users and their partners	Yes. HBV screening and vaccine for gay men as part of Men's Health Project. Hepatitis A/B/C screening for IDUs at Addaction. Hep B vaccine offered to sex workers: drop-in session at Addaction
Availability of Hepatitis A vaccine	Yes
Safer sex information to all attendees	Yes
Cervical cytology screening	Yes. Colposcopy clinic once a week
Emergency contraception	Yes. Offered to users of GUM service
Advertising and public relations activity appropriate to the local community	In part. Links with local schools, Men's Health Project, Addaction, FP Clinic. Need more work with asylum seekers and BEM
Antiretroviral therapy and monitoring according to national guidelines	Yes
Palliative respite care	No. Lack of services in Walsall
Co-ordinated access to social care	In part. Limited links to social care provision
Psycho-sexual and Impotency services	Limited service. Once a month for diabetics
Support for families, partners inc pre-test counselling, support and safe sex advice	Yes
Referral to other agencies such as drug services, psychologist where relevant	In part. Good links with Addaction. Limited mental health and psychological support for people with HIV and asylum seekers
SERVICES FOR PEOPLE UNDER 25	
Written policy on management of under 16s who are sexually active	Yes
Defined routes of liaison bet GUM & FP	In part. Lack of integrated working
Service development in conjunction with users of the service	Patient satisfaction surveys, positive people users group, suggestion box in clinic
All staff should have training in child protection (Childrens Act /child abuse)	In part. Have protocol on management of STI in under age children
Clear referral pathways to social services	No. Links with some services, but limited links with social services
Liaison with drug abuse service	Yes. Addaction
CLINIC FACILITIES	
Sound proofing of clinical areas	No. Not purpose built clinic
Reception area –allows privacy	No. Reception area opposite waiting room – limits privacy; too small
Waiting area	In part. But small, too close to consulting rooms and HA room
Consultation/examination rooms	Inadequate. Very poor. Male and female areas but consulting rooms inappropriately furnished. No extra room if patient unwell
Health adviser rooms	Yes. But room is close to waiting area. Privacy is an issue.
Nurse treatment area	Inadequate. Very small, cramped. No room for equipment
Laboratory area	Inadequate. Small, cramped
Male and Female toilets	Yes
Dirty Utility	No
Storage	No
Administration rooms	Inadequate. No dedicated rooms
Confidential data handling/notes separate to hospital system	No. Lack of storage at the clinic means that some patient notes are being stored off site in areas accessible to other hospital staff

Source: Evaluations standards, references 33, 34, and 35.

A Consultant in Community Gynaecology, with accreditation in GUM, would meet these demands. There are very few such appointments nationwide. A model job description has been obtained from the Royal College of Obstetricians and Gynaecologists. This person would lead on FP services across Walsall and assist the Walsall GUM department in developing integrated services across the borough. A particular priority would be increasing access to contraception and early termination of pregnancy. An input into the commissioning process would include taking a lead on the increasingly complex process of co-ordinating Walsall's cervical screening programme and addressing neglected areas such as infertility.

Select Committee inquiry

The House of Commons Health Select Committee has published its inquiry on sexual health and highlighted a major public health problem and increasing crises **(37)**. The picture is of a continuing decline in the nation's sexual health, with services unable to cope and an increasingly demoralised but willing workforce.

One of the recommendations was that Chlamydia screening should be rolled out more rapidly and that suboptimal tests should be withdrawn in favour of molecular amplification tests. Walsall's GUM consultant has been struggling to introduce the new screening tests for quite some time, since traditional tests are throwing up too many false negatives.

HOUSE OF COMMONS SELECT COMMITTEE RECOMMENDATIONS

The most important ones relating to standards, targets, and services are as follows:

- ❑ Sexual health and HIV to be included in local delivery plans and strategic health authorities to use standards to manage PCT's performance
- ❑ National service frameworks to be established for sexual health
- ❑ Manpower requirement and expansion of GUM consultant posts
- ❑ Additional and recurrent revenue commitment £22-30m a year to be allocated specifically to GUM and HIV services
- ❑ Improvement of GUM clinic facilities and premises
- ❑ Chlamydia screening using molecular amplification tests to be rolled out more rapidly
- ❑ Department of Health to review access to anti-impotence treatments and include sexual dysfunction in wider sexual health strategy
- ❑ Contraceptive services to be prioritised
- ❑ Government to facilitate open access for termination of pregnancy and early medical abortion in a wider range of health care settings.

Walsall's sexual health strategy

B. Services

The following areas warrant particular attention:

- A commissioning toolkit has been produced and this will provide the basis for service standards **(33)**. Current service provision is fragmented.
- The Walsall GUM department is understaffed and there is urgent need to appoint a second GUM consultant. Waiting times are under threat and there are serious issues around lack of space.
- There is an urgent need to appoint a community gynaecologist, to enable GP training, develop Tier 2 services in primary care, and extend the cervical screening programme (there is the potential to access large numbers of females aged 19-64 years for sexual health interventions).
- There are a number of issues around improving contraceptive services. The most important is the need to expand the number of places where young people can access. A Brook Clinic presence should be explored to support the work of the Hatherton Centre.
- Tackling inequalities in access to abortion is a priority. Investigations into late referrals need to continue and the newly introduced service for early medical termination evaluated.
- The current targeting of services to vulnerable groups needs to be reassessed to ensure diversity and equality issues are being met.
- More community based services of the one stop shop type are required across the borough.
- Better support is needed for people living with HIV, around housing, mental health, reducing stigma, and improving confidentiality.
- Walsall is committed to providing services that are needs based and client led, and will join in with national evaluations when appropriate and share in good practice where identified.

Three levels of service provision in the National Strategy for Sexual Health and HIV

Level 1

To be provided by all primary care teams and specialist services

- Sexual history and risk assessment
- STI testing for women
- Chlamydia screening in women ages < 25 years
- Assessment and referral of men with symptoms of STI
- Contraceptive information and services
- Pregnancy testing and referral
- Cervical cytology screening and referral
- Hepatitis B immunisation
- HIV testing and counselling

Level 2

To be provided by primary care teams with a special interest, or commissioned from specialist providers

- Testing and treatment of STIs
- Chlamydia screening women ages < 25 years
- Partner notification
- IUD and contraceptive implant insertion
- Vasectomy

Level 3

To be provided by specialist services

- Specialised STI management and partner notification
- Specialised HIV treatment and care
- Specialised and highly specialised contraception
- Outreach for STI prevention
- Outreach contraception services

CONCLUSIONS

The first national strategy for sexual health and HIV addresses a recent epidemic of nationwide sexual ill health. Incidence of sexually transmitted infections (STIs) has risen dramatically, causing a crisis in delivery of genitourinary medicine (GUM) services. Walsall's GUM Department is cramped in the face of unprecedented demands, presenting the need for more staff, space, and privacy. There are also increasing demands for GUM to outreach into the Walsall community, at a time of overwhelming need for a second GUM consultant and more support staff to sustain the volume and range of activities.

The national strategy has informed an approach to address sexual health across the borough. Although recent trends show a decline in teenage conceptions, a different picture emerges for pregnancy ending in termination. Abortion figures in 2001 showed that the West Midlands (especially Dudley and Walsall) had higher than average NHS terminations performed at 13 or more weeks of gestation. Clearly we need to do more to ensure that women access earlier abortion.

The key to improving access to sexual health services lies in the community delivery of integrated GUM and Family Planning (FP). A consultant in Community Gynaecology would be ideal to liaise with the Manor and oversee many of these access and integration issues in Walsall, as well as monitor abortion. Otherwise, activities are in place to deliver on the national strategy and meet targets.

A House of Commons Select Committee made recommendations to address the present crisis of sexual ill health. Three are worth noting:

- Sexual health to be included in local delivery plans and strategic health authorities to use standards to manage PCT's performance
- National service frameworks to be established for sexual health
- Additional and recurrent revenue commitment of £22-30m a year to be allocated to GUM and HIV services

Walsall recommendations

There are a number of competing interests and the following is an attempt to rank the recommendations needed to make a strategic difference in improving sexual health across Walsall:

1st level

- There is need to appoint a second GUM consultant, more support staff, and tackle serious issues around lack of clinic space.
- There is need for a community gynaecologist to tackle access to abortion and develop services in primary care and other key community areas.
- More community based services of the one stop shop type are required for young people and a Brook Clinic presence should be explored.
- Crisis Point has highlighted a gap in Walsall's service provision for victims of rape and there is need to fund and support this agency.
- Better support is needed for people with HIV, around housing and mental health especially.

2nd level

- The Teenage Pregnancy Media Group needs to be broadened to include all sexual health.
- More work is needed involving parents through schools and young men regarding condom use.
- Ensure GUM resources to sustain outreach activity in association with continuation of the existing Men's Health project.
- Joint working undertaken between SAFE and Addaction to reduce risk taking behaviour of commercial sex workers needs strengthening.
- Further support the Terence Higgins Trust project addressing HIV in Africans.

3rd level

- Targeting services to vulnerable groups needs to be reassessed to ensure diversity and equality.
- Introduce Chlamydia screening using molecular amplification tests.
- Waiting times for colposcopy are unacceptably long and needs to be a priority area of the cervical screening programme in Walsall.

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Many of the references can be accessed through the name of the organisation and its website. The Department of Health website provides a wealth of information on sexual health through its A-Z index and the use of keywords.

NOTES